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MENTAL HYGIENE

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Articles

Book Reviews

Notes and Comments

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Reorganizing to prevent and control disordered behavior

The official title of the project from which the materials of this report are derived—The Prevention and Control of Disordered Behavior in San Mateo, California—may seem ambitious to some readers. Indeed it is. Knowledge of the mechanisms and motivations activating the behavior of the human personality, and of the etiology and epidemiology of social misbehavior is still meager, albeit steadily increasing. Services designed to deal with social pathology about which the community is compelled to be concerned are conducted under many different auspices, dealing separately with many different episodes and symptoms. To presume that in three short years, any community anywhere could take command of such diverse symptomatology and efforts, point them toward this ideal goal, and reach full achievement would indeed be ambitious fantasy.

Nonetheless, by 1953, five years of focused and articulated research, plus fifteen prior years of experience in dealing with problems of community programing, organization and administration, had convinced the designers of this project that the time had come to make a beginning. Only by grasp-

Bradley Buell is executive director of Community Research Associates, Inc., which planned and conducted the experiment in community planning and organization reported in this paper. Paul T. Beisser is associate director for adjustment services, with supervisory responsibility for the project. John M. Wedemeyer was the project's resident director. Other members of the project staff included Robert S. Booth, Family Center director; Madeleine O'Callaghan and James R. Boorman, case work consultants, and Kathren McKinney, research analyst. Allen F. Olinger, M.D., acted as consulting psychiatrist and Andrew Mikita as consulting psychologist. Specially assigned case workers were Mrs. Ruth Fuhrman and Eugene Kelly, welfare department; Mrs. Mary Miles and Robert McMillan, probation department, and Mrs. Mary Engstrom, county school department.

The project was sponsored by the Citizens Advisory Board, County Board of Supervisors, and County Council of Social Agencies, all of San Mateo, Calif., and financed by the Rosenberg Foundation, Grant Foundation and San Mateo County Board of Supervisors.

ing the nettle of a positively avowed goal and subjecting preliminary objectives, concepts and methods to vigorous laboratory experimentation did it seem possible to discover whether prevention and control in this disturbed area of community life might be possible, and if so what it would take ultimately to achieve it. Thus, this conviction had emerged out of a background sufficient to contribute preliminary concepts of both objectives and methods, and the project was initiated January 1, 1954 in San Mateo County, Calif.

BACKGROUND

In 1947, with financing from The Grant Foundation, Community Research Associates, Inc. undertook a major research project, the assembling of materials for a comprehensive exposition of the problems involved in achieving better planning of community welfare, health and recreational programs. An important segment of the source material came from an extensive statistical study conducted in cooperation with the Greater St. Paul Community Chest and Council—an examination of all cases under care during November 1948 by the 108 agencies serving that community.

The results of this work were published in 1952.[1] Among many findings were two fundamental conclusions:

- First, with one exception, community services were not organized to control or prevent the basic community problems with which they were dealing. Rather than being directed to problem-solving, the common orientation was the provision of needed service, which, though laudable in itself, constituted an open-end objective. Moreover, the need for service was separately interpreted by each agency and each administrator. The public health program for the prevention and control of communicable disease and reduction of the hazards of maternity and infancy was the notable exception.

- Second, these problems, and therefore the services relating to them, were highly concentrated and overlapping in a quite small group of seriously disorganized multiproblem families. In St. Paul this group—only 6% of all families in the community—accounted for by far the largest portion of the service provided by all major administrative units.

Against the background of these findings, The Grant Foundation, later joined by the Louis W. and Maud Hill Family Foundation of St. Paul and the Rosenberg Foundation of San Francisco, provided funds to conduct a series of related projects designed to create, invent and test concepts, policies and procedures requisite to the beginning development of community plans for the prevention and control of the principal psychosocial disorders.

As the overall design took form, three projects were to be experimental each in a different community; each focused on one of three major problems. Because the St. Paul study had sharpened concepts regarding the key role of the family in both etiology and therapy, a fourth project was designed to produce data for a basic treatise on family diagnosis and treatment of psychosocial disorders.

By 1954 the three local experiments were under way. In Winona County, Minn. the project was focused on the problem of *dependency*. (In 1956 this was expanded into three counties, under joint sponsorship with the State Department of Public

[1] Bradley Buell and associates, *Community Planning for Human Services*, New York, Columbia University Press, 1952.

Welfare.) In Washington County (Hagerstown), Md. the focus was on *indigent disability*. The San Mateo County, Calif. project was primarily concerned with *disordered behavior*. Basic case materials for the concurrent family study were obtained not only from the seven cooperating private family service agencies [2] but also from these three CRA experiments.

Each of the three projects was organized with the joint sponsorship of key community groups, including a citizen board, serving as advisers to the project. Each project plan was based on a survey of the county's problems and services. Full reports [3] of the surveys, including the basic design of the plan, were published and approved by the key sponsoring bodies.

SAN MATEO COUNTY AND ITS PEOPLE

Located in the dramatic great Bay Area, San Mateo County stretches south down the peninsula from the San Francisco line to Palo Alto and the Stanford University campus. On the west is the Pacific Ocean; on the east the bay, cloven in the middle by the rugged peninsula range. Old fishing villages of Half Moon Bay and Pescadero, some remaining cow country and redwood timberland on the western side are swept constantly by the chill winds of the blue Pacific. To the east, in more protected country nestling between the mountain foothills and the bay, one finds the modern, thriving, colorful metropolitan-suburban county of San Mateo.

It is a prosperous and rapidly growing county, essentially middle-class and native white. The median family income of $4,467 is well above the $3,067 median for the U. S. The foreign-born and non-white segments amount to 10.3% and 2.3% respectively of the county population. The total population, 307,000 in 1954 when this project started, had grown to 370,000 when it ended.

The 5-man elected Board of Supervisors, the governing body of the county, is among the few in California (or in the U. S.) to employ a professionally trained county manager to assist in the administration of its affairs. Annual health, welfare and recreational expenditures total over $15,000,000, well above the average of those U. S. counties for which data are available. By any comparable standards the principal agencies are well manned and administered; initially it was professional leadership from this group which brought the project to San Mateo. Uniquely, in our experience, the larger public agencies are housed at the Health and Welfare "Campus," a square block centrally located in San Mateo City. Here one finds a modern health and welfare administration building, a community hospital and outpatient department, a child guidance and adult psychiatric clinic and a temporary receiving home for children.

This report can do no less than pay high tribute to the professional and lay leaders in all administrative and staff echelons, whose cooperation and participation made possible the practical operation of this project. A testimony to the quality of that

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[2] Brooklyn Bureau of Social Services and Children's Aid Society, Brooklyn, N. Y.; Family Service of Cincinnati and Hamilton County, Ohio; Family and Children's Service, St. Louis, Mo.; Family Service of St. Paul, Minn.; Family Service of Milwaukee, Wis.; Family and Children's Bureau, Columbus, Ohio, and Family and Child Services, Washington, D. C.

[3] The Prevention and Control of Disordered Behavior in San Mateo County, California (July 1954), The Prevention and Control of Indigent Disability in Washington County, Maryland (July 1954), The Prevention and Control of Dependency in Winona County, Minnesota (July 1953).

leadership may be found in the fact that the values accruing from the experiment are now to be maintained under local administrative and financial auspices.

CONCEPTS

The principal objectives and methods of the project have their foundation in six elemental and interrelated concepts. Taken together they express the philosophy of CRA's basic approach to the problems of community planning. We shall identify and briefly articulate them.

Psychosocial disorders. In every organized society, certain kinds of social behavior have been either disallowed as inimical to its cultural standards or disvalued as unsatisfactory expressions of its cultural objectives. In our generation of American culture these deviations from social norms usually and somewhat loosely have been referred to as social problems. In recent years, however, the more precise term, psychosocial disorders has come into professional usage. As herein used, it means that:

- The problem of behavior arises because of the individual's inability to cope successfully with the requirements of social living.

- It is behavior of concern to society, which in the majority of instances means to the community in which the person lives and to the agencies which act in the community's behalf.

- Cause and cure relate not only to pathological processes which impair the functioning of the individual personality or family, but equally to the circumstance with which the social failure is identified.

Disordered behavior. Inherent in the decision to set this project toward a "preventive" goal was the necessity for also deciding, in satisfactorily measurable terms, *what* it was intended to prevent and control. "Disordered behavior" as used in this report means behavior which is either legally prohibited or generally disvalued by society and permitted only if in conformity with legally or officially prescribed restrictions. Although various categorical groupings were used in the course of the project, the simplest are these:

- Adult disorders (as indicated by major crimes, minor crimes and misdemeanors, voluntary admissions and commitments to mental institutions)

- Marital disorders or disfunctioning (as indicated by divorce, official separation or desertion, separation of children from their own home to agency care)

- Child disorders (as indicated by officially reported delinquency and truancy, non-economic school dropouts, commitments to mental institutions)

Thus, in this classification, adult major and minor crimes, juvenile delinquency and truancy constitute symptomatic behavior which is legally prohibited. Admissions to state mental institutions, divorce, official separation and desertion, separation of children for placement, and school dropouts represent behavior which, although permitted, must be subject to the restrictions or protections of legal or official procedures indicative of the community's belief that the presence of these conditions negates its cultural objectives for personal and social living.

Use of this definitive concept has certain positive community planning assets: 1) the data are a matter of public record; community rates and other epidemiological

data can be obtained; 2) families presenting these symptoms of disordered behavior absorb 73% of the money spent for community services having a social adjustment function; 3) evidence suggests that the most severe levels of pathology are found in these families.

Control. An old concept adapted from the public health field, control entails a systematic program for measuring the community-wide spread, intensity and trend of a defined problem equally combined with systematic efforts to reduce or curtail it.

Prevention. This concept is not borrowed from public health. Present knowledge about disordered behavior does not warrant expectation that practical results can be obtained from attempts to prevent the onset of its symptomatology. Programs based on plausible generalities about what should prevent the onset of pathological behavior have produced no evidence of a measurable effect on the community-wide volume or severity of these disorders. Any practically designed preventive plan therefore must be based in the first instance on *preventive intervention* after symptomatic behavior manifests itself, to stop or delay further deterioration, or on *rehabilitative* efforts, to raise the current level of social functioning.

Integrated service. The fact that a substantial proportion of the individuals and families with psychosocial disorders suffer from multiple physical and social impairments for which they receive special services from numerous agencies has been well documented in prior CRA studies. Further evidence will be presented in this one. Also, the three terms now in use to indicate the level at which agencies may work together in the community may be described as follows:

- Cooperation: The expression of general good will, intent, friendly relationships and willingness to serve on all community committees is the rule, not the exception.

- Coordination: Firm agreements at the administrative level regarding the particular problems which particular agencies will handle or functions which they will perform are not the rule. However, illustrative instances of such agreements are not uncommon.

- Integration: The actual pooling of specialized service to achieve a common diagnosis and unified treatment plan for a particular family is almost never implemented.

During the San Mateo project, the cooperative intent of all concerned was excellent. Agreement to overall policies at the administrative level necessary to coordinate project with agency operations was generously given. The main difficulties encountered were with truly integrating and implementing particular services in particular cases at the working level. In many instances, these demanded fundamental changes in philosophy, policy and tradition.

The family role. The last and most important concept is the belief that all data should be structured from a family base and that a family diagnosis is a prerequisite to the treatment of all psychosocial disorders. Amplification and documentation of this thesis will be contained in a comprehensive work to be published in 1959.[4] Suffice it to say that all knowledge of the sequence of the biological and psychological processes of personality formation through which socialization is achieved by the child points to the dominant role played by the

[4] *Family Diagnosis and Treatment of Psychosocial Disorders,* manuscript in process for publication.

mother, father and other members of the family in the formative years of infancy, childhood and adolescent youth. This in itself has etiological implications sufficient to compel the application of this concept to this project.

OBJECTIVES

The objectives of the San Mateo project may be stated simply as follows:

- To identify and isolate the problem of disordered behavior in the county; to secure epidemiological data about it.
- To apply concepts inherent in a family approach to the analysis of all data and to the therapeutic processes essential to preventive intervention and rehabilitative effort.
- To apply the concept of integration in the planning and execution of these therapeutic processes.
- To create, invent and test new methods and tools essential to the application of these concepts.
- To evaluate the results within the frame of reference of community planning.

BASIC METHOD

In brief summary, for the purposes of this introduction, operational methodology was of two main kinds:

Statistical reporting. In the initial planning study the 72 agencies providing welfare, health and adjustment service to San Mateo County reported on a detailed schedule the problems presented by, and services rendered to, all families in their loads during January 1954. Beginning with that month, the ten agencies [5] dealing with disordered behavior used a modification of this schedule to report each month all new cases accepted. The problem and service classifications of the schedule were adapted from the Family Unit Report System used in the St. Paul study of 1948.

Intensive diagnostic workup and treatment planning for a small group of multiproblem, seriously disorganized families. Of the 231 families selected for diagnostic and treatment processing during the project period, 201 were recidivist families.

It should be made clear that this was not a clinical operation. Initially, diagnostic data about these families were confined to information already available in agency records. Diagnoses and treatment plans were subsequently formulated by a special project unit, the Family Center. These were then transmitted and interpreted to the agencies handling the case, and responsibility for carrying out the treatment plans remained with those agencies. The purpose of this part of the experiment was not to set up new therapeutic services in the community but rather to devise and test new methods for better use of those already available. In the later stages, shifts were made which gave the project more control over the treatment process. This did not, however, approach a completely controlled and integrated clinical setting, and was not intended to do so.

The project staff consisted of a director; a statistician; a director of the Family Center, an experienced casework administrator; initially 3, and later 7, well-qualified

[5] Adult Probation; Juvenile Probation; California Youth Authority; Catholic Social Service; Office of the County Clerk; County School Superintendent; State Department of Corrections; State Department of Mental Hygiene; County Welfare Department (aid to needy children and child welfare services); District Attorney's Office.

caseworkers; a consultant psychiatrist, and a consultant psychologist.

With this description of the sponsorship, concepts and objectives of the project, we now turn to analysis of findings and experiences which relate to epidemiological factors, pathological factors, preventive and rehabilitative potentialities, issues of method and structure, the San Mateo solution and the San Mateo plan.

EPIDEMIOLOGICAL FACTORS

Two extremely effective road blocks have confronted previous efforts to fashion a systematic way of building up scientific data about the community's total problem of seriously disordered or maladjusted behavior—the symptomatology, prevalence and incidence; the pattern of their concentration and the patterns of other essential characteristics relevant to what is being done, or what might be done more effectively, about their prevention and control.

The first arises from the fact that during the long history of effort to protect the social values from the behavioral disorders already alluded to, almost all segments of the community's services have been organized essentially to deal with the symptoms of behavior rather than with the pathological processes which give rise to them. The mental hospital program rooted in medical concepts and knowledge perhaps more nearly approaches an exception. The consequent inability to differentiate between the issues involved in *identifying symptoms* and in *treating pathological conditions* has long been, and still is, a pervasive source of confusion.

Grouping such apparently diverse behavior as divorce, crime, mental illness or separation of children from their own homes, as these project materials do, is a step toward resolving the confusion. These are administrative classifications, determined solely by the kind of symptomatic behavior traditionally assigned to a particular administrative program. In reality they have a common base, since all are clearly symptomatic of pathological behavior which society—that is, the organized community—officially designates as not being conducive to the maintenance of its social standards. However, to have any practical use for the purposes of community programing, more precise symptomatic regrouping for diagnostic and treatment purposes, although desirable and essential, must relate to this traditionally fixed administrative base.

The second obstacle comes from the fact that the only consistently available data must be obtained from records regularly kept by many different agencies for their own separate administrative and program purposes. Their records are not devised primarily to tell the community what it needs to know about the common problem of disordered behavior.

The procedures of this project at least partially surmounted these two obstacles. While the resulting data indisputably have limitations, they tell us a good deal not heretofore known about the form and shape of the total community problem of disordered behavior.

COMMUNITY RATES

The confusion between symptomatology and pathology, and the diversity and disparity of agency records, in the past have seemed to impose insuperable obstructions to the establishment of community rates, for either the totality of disordered behavior or most of its principal symptomatic segments. Yet this is prerequisite to the development of any program for prevention and control, for it makes it possible

to acquire knowledge about such epidemiological characteristics as volume, spread, distribution and intensity.

The simple fall or rise of rates does not give a precise test of the effectiveness of a program, but does provide the factual background against which a test must be devised. However, the ultimate interest of the citizens of a community, it hardly need be pointed out, is not primarily in program methodology but in whether their problems are getting better or worse. The rate, and its fluctuation within the community, also is a constant stimulus to inquiry and research; comparative rates of other communities are even more so. For example, during the month of the three initial planning studies, the prevalence rates of disordered behavior per 1,000 families were 27 in San Mateo County, 26 in Winona County, 46 in Washington County.

Part of the higher rate in Washington County can be accounted for by differences in legal and administrative procedures that can be identified and discounted, but part is undoubtedly owing to factors in community pathology. Our own studies were not of sufficient depth to do more than provide clues; obviously these and other clues like them must be the focus for further research if community planning is to achieve a scientific base.

PREVALENCE AND INCIDENCE

The above rates raise a debatable question: Is prevalence or incidence of greater epidemiological significance to this problem? Prevalence rates generally have greater significance in indicating chronic conditions where the duration is long and the annual accretion relatively small. Incidence rates usually are more significant for acute conditions lasting for short periods.

If one judges by the way administrative agencies handle their cases and keep their records, the problem of disordered behavior presents a mixture of acute and chronic conditions. Commitments to mental hospitals and correctional institutions, together with the placement of children either in institutions or foster homes, reflect care over fairly long periods. Over a third of San Mateo's annual prevalence is accounted for by such cases. In institutions the individual is controlled and supervised; he is not free to produce further episodes. In contrast, those involved in minor crimes, misdemeanors, truancy, juvenile delinquency and divorce are treated episodically —either dealt with immediately or put in detention or on probation for relatively short periods. Family incidence of such behavior constitutes about three-fourths of San Mateo's annual workload; obviously there is overlapping between these two proportions. The evidence suggests, however, that many of these episodes actually reflect a chronic condition. In 1956 two-thirds of the "new" cases coming to the juvenile division of the Probation Department were from families dealt with in prior years. Similarly, a quarter of the families known because of minor crimes, misdemeanors and divorces had been previously known to official community agencies.

In Table 1, which shows annual incidence and prevalence rates of disordered behavior in 1956, one finds the basis not only for determining the total number of families with disordered behavior with whom the agencies worked during a 12-month period, but also for determining the relative amounts of care given to the various problems.

A special value of both rates is that they dramatize the large volume of traffic in symptomatic behavior dealt with by the community's adult judicial and protective system—divorces, official separations and

TABLE 1

Annual incidence and annual prevalence of disordered behavior in San Mateo County, 1956

BEHAVIOR CATEGORY	ANNUAL RATES PER 1,000 FAMILIES		PERCENTAGES	
	INCIDENCE	PREVALENCE	INCIDENCE	PREVALENCE
Adult disorders	13.9	22.2	47.4	49.9
•Major crimes	1.6	1.9	5.2	4.3
•Minor crimes and misdemeanors	8.9	11.0	30.6	25.0
Mental illness (institutionalized)	3.8	9.6	12.9	21.5
Marital disorders ••				
Divorce, desertion, separation	9.8	12.8	33.6	28.9
Separated children	1.7	3.5	5.9	7.8
Child disorders	6.1	10.1	20.8	22.7
•Youthful unsocial behavior	5.8	9.1	19.8	20.4
Separated children	0.4	1.1	1.3	2.4
• In correctional institutions (included in adult and child disorders)	2.0	4.0	6.7	9.0
Adult	1.5	3.4	5.2	7.6
Child	0.5	0.8	1.5	1.8
All types of disordered behavior	29.3	44.4	100.0	100.0

•• Unduplicated count not available.

desertions, and minor crimes and misdemeanors (which constitute the great bulk of the overall crime classification). These two categories account for 64% of the annual incidence of disordered behavior, 54% of the annual prevalence. Generally speaking, communities have ignored completely this large area of symptomatic behavior in planning therapeutic services.

We see also from this table that in three categories the annual prevalence rate (as indicative of the amount of care or service required) is very much higher than annual incidence (that is, frequency of occurrence). In the case of mental patients it is nearly three times higher; it is twice as high for those in correctional care and also for separated children. As symptoms of disordered behavior are now handled, these are the long-time or "continuing care" categories. Others are dealt with as episodes come to the attention of the community and its agencies.

These apparent differentials between acute and chronic in community rates also are reflected in the distribution of costs. The total expenditure in San Mateo in 1956 on account of disordered behavior was $3,497,000 ($9.44 per capita of the population). Of this total amount 70.5% was accounted for by these three high-prevalence categories: mental illness as indicated by institutional admissions (45.7%); those receiving care in correctional institutions (15.1%); and child placement (9.7%).

Although the low-prevalence (but high-

incidence) categories account for only 29.5% of the total cost, it should be pointed out that there may be long-range cost factors to be examined. For example, various members of one family brought before adult or juvenile courts half a dozen times, and repeating this again and again in succeeding years, may cost the community just as much or more than a traditionally-designated chronic case committed for relatively long-term care.

By the end of 1956, the cumulative incidences of disordered behavior had climbed to nearly 11,000 families (9% of the current family population). In other words, to the 2,900 families identified in the initial prevalence study of January 1954 had been added an annual average of about 2,700 families. Taken by itself this fact has little meaning, except perhaps eventually to give clues as to the proportion of the population likely to be "attacked" at some time by the "disease" of disordered behavior. But the necessity of maintaining this cumulative roster from which to devise annual rates provides a gold mine of information available for productive digging by imaginative researchers. To cite only one instance, in not too long it will be possible to answer the question from these rates: Is there a social inheritance of pathological behavior from one generation to another? and if so, to what degree?

CHARACTERISTICS OF FAMILIES WITH DISORDERED BEHAVIOR

Age. With one categorical exception, disordered behavior is a pathological condition of youth and middle age. The exception is mental illness of a severity requiring institutional commitment. Among adult heads of families involved in all episodes of disordered behavior, 70% were under 45 years of age. Commitments because of mental illness account for only 11% of the annual incidence of disordered behavior among family heads; of these, fewer than half (47%) were under 45. Of family heads involved in all other adult disorders, 86% were under 45; of those in families having marital disorders, 85% were under 45.

The heavy concentration, 76%, of adult disorders (exclusive of mental hospital commitments) is in the age brackets of 18 to 44. Most child disorders, 92%, are in the years between 12 and 17; of the children separated from their own homes, 43% are under 10, 27% are 10 to 14, and 30% are 15 to 17. Most marital disorders, 69%, are concentrated in the years between 25 and 44.

Family structure. Disordered behavior is also a condition associated with family structure deviant from the normal. As can be seen in Table 2, there are more 1-person families, many more broken families with children, and fewer where both parents are in the home, in the disordered behavior load, than in the total San Mateo population.

Some qualification of the data on family structure is necessary. Family information from mental hospitals, judicial and correc-

TABLE 2

Family structure comparison

	PERCENTAGES	
TYPE OF FAMILY	ALL SAN MATEO FAMILIES	DISORDERED BEHAVIOR FAMILIES
1-person family	18.6	26.6
Families with children		
Both parents	40.9	20.8
Broken	4.1	24.0
Other adult families	36.4	28.6
Total	100.0	100.0

tional authorities was sparse, or entirely absent at the time of the original study. During the course of the project the State Department of Mental Hygiene made special efforts to obtain family identifying data, and this is now believed to be quite accurate. This was not possible with the judicial and correctional authorities; family data in much of their administrative recording are negligible and could not be supplemented within the resources of the project. To what extent the 1-person families in these categories actually have no family ties in San Mateo is still uncertain.

Mental illness vs. character disorders. Obviously, knowledge about relative distribution among mental illness (psychoses, prepsychotic or other severe conditions), mental deficiency and character disorders of the total disordered behavior load is of high importance from the standpoint of both pathology and planning. The schedule on which the agencies reported called for this information, but almost none had it except the mental health agencies. Practically speaking, this meant the state hospitals, since the two local psychiatric clinics have contact with no significant number of disordered behavior families.

The only firm fact yet available, therefore, is that in the total annual prevalence load 24% are cases of mental illness and retardation severe enough to require admission to the state institution. One other clue is available. The 231 families worked up by the Family Center were selected from those in the total load believed to reflect the most severe family pathology. Among these families, severe mental illness was found in 31%, either in the family heads or in the children. CRA's general experience, as well as that of others, would testify that character disorders considerably outweigh severe mental illness in the total load, but even a shrewd guess as to the relative proportion is as yet impossible.

Indigency. Indigency (that is, dependency and illness requiring subsidized community health services) is much more prevalent in disordered behavior families than in the total community—in 27% of disordered behavior families, in 6% of all families in the community. On the other hand, disordered behavior is not predominantly derived from families of sub-marginal income status: 73% of the families involved were economically self-sufficient as compared with 27% who were dependent or medically indigent. The factor of indigency is considerably higher, however, among families with children—in 46% of disordered behavior families with children, in 5% of all families with children.

Multi-problem concentration. In the initial study 40% of the community's total cases of maladjustment were identified as multi-problem families, using the original definition of the 1948 St. Paul study (that is, families with some combination of the three major problems—dependency, ill health and maladjustment). The decision to concentrate on the precisely defined problem of disordered behavior helped clarify the fact that separate symptoms of maladjustment actually are dealt with as separate problems by separate agencies, and that these multiple concentrations were no less indicative of "multiplicity" than those including dependency or disability.

With this base, 48% of the cases of disordered behavior proved to be multi-problem families. In a quarter of these the concentration was exclusively in the disordered behavior categories; in the remainder it was combined with the other major problem categories—dependency and ill health.

CHARACTERISTICS OF THE COMMUNITY PROGRAM

What is done about disordered behavior in San Mateo County presents a curious mixture of segmented state and local activity, along with some slight combinations of the two; of complete disregard for large blocks of cases by everyone except the police and the courts; and a great, but confused, anxiety about constructive service to other segments. The same would be true for any other county in the United States.

The state's primary concern in the area of disordered behavior is with mental illness and mental deficiency, through its state hospitals; with a portion of adult crime, especially major crimes, through its adult correctional institutions; and with a very small part of juvenile delinquency through the Youth Authority. These responsibilities are discharged for 24% of the annual prevalence load, and because they all entail very expensive long-term care they represent 50% of the annual cost.

The county's primary responsibility in this area is for all incidents of crime—especially minor crime and misdemeanors—which do not result in commitment to the state adult correctional institutions; for all child disorders, except the relatively small numbers of juvenile delinquents committed to the Youth Authority; for all separated children; and for adjudications concerning divorce, desertion and separations. This accounts for 76% of the families in the annual prevalence load and the remaining 50% of the cost.

The small overlap of state and local activity is mainly in the administrative processing of cases for admission to the state hospitals, and in transferring and committing of cases from local juvenile detention or probation to the State Youth Authority.

In epidemiological analysis, however, the important question should be what therapeutic service is now rendered with the intent either 1) to intervene to prevent further deterioration or 2) to rehabilitate to a higher level of social functioning. We believe it fair to say that all of California's state hospital and correctional services are now organized with a therapeutic purpose—that is, to "treat" the case to the best of their ability with the resources at their disposal. They are at the forefront of state services in these fields. With the exception of juvenile cases transferred to the Youth Authority, however, there is no constructive intervention at the local level with the intent to prevent the necessity for commitment. The processes of commitment to the state hospitals have been strictly routine;[6] perhaps the commitment of criminals to the adult correctional authority is inevitably determined by the severity of the sentence. Rehabilitation has been a state goal, but only after symptomatic evidence of the severest types of pathological behavior.

In the county, it is fair to say that there is no therapeutic service for the large block of cases involving divorce, minor crimes and misdemeanors. There is humane and efficient law enforcement; but there is no therapy. On the other hand, beyond question the services of the probation department, the health and welfare department, the guidance division of the county school department and other community social agencies are therapeutic in their intent. The community supports these agencies because it expects them to do something con-

[6] During the later stages of the project, plans began to take form to improve coordination of local psychiatric inpatient and outpatient services with the processes of admission to the state hospitals.

structive beyond enforcing legal penalties or procedures.

Consequently, families in the total annual workload are served approximately as follows: 24% by state agencies with therapeutic intent; 24% by local agencies with therapeutic intent; and 52% by local agencies with non-therapeutic intent. Of the families in the local workload alone, 31% receive therapeutic service and the other 69% do not.

Moreover, practically all local service is rendered on account of the community's anxiety about children. Its two main concerns have been with child disorders—delinquency and truancy—and with children who must be separated from their homes and placed in institutions or foster homes.

In the families of these children, to be sure, are found adults who have committed major or minor crimes and adults who have deserted, been divorced or separated. In the initial study of prevalence it was found that through these recipients of child care, local therapeutic service "seeped in" to 19% of all families with adult and marital disorders; the remaining 81% received no therapeutic service. However, any service rendered to families with these adult problems is primarily on account of their children.

The reasons for community concern about children whose behavior or condition is falling below accepted social standards are obvious and need no elaboration or justification. But such exclusive or near-exclusive therapeutic attention disregards a much larger segment of behavior unquestionably symptomatic of personal and family pathological conditions of real community concern, and distorts etiological perspective. Preventive intervention in child disorders and child placement can be successful only as it pushes back to a concern about the families from which these children come.

A FOCAL POINT

This near-exclusive concentration of local therapeutic service on child problems also assumes new significance when related to the factor of recidivism. In this project, for the first time anywhere, opportunity was afforded to collect accurate data about the degree to which recidivism accounts not only for the total volume of disordered behavior but also for the principal symptomatic behavior toward which the community's programs are directed. "Recidivism" as used here applies to the family, not the individual. It means simply that either the family as a unit or some member of it has come up for official action more than once during the period covered by the project data.

During the three years of the project 18.5% of all the disordered behavior families (10,954) with which the community was concerned were repeaters. This represents 1.7% of all families presently in the community. They accounted for 40% of all the instances requiring official action during the period of this research. In Table 3, annual prevalence refers to the total number of cases in agency workloads at any time during the year; annual incidence refers to the total number of episodes arising during the year. The table shows how significant recidivism is from either point of view. It also shows that recidivism is a much more important factor in some categories than in others.

It is apparent that recidivism, whether measured by prevalence or incidence, occurs more often in the two categories concerned with children than in any of the others. The fact is that families with children account for 78% of all recidivist families. By definition, they account for 100% of all recidivist families in the subcategories of "child disorder" and "separated children."

TABLE 3

Recidivism among disordered behavior categories

BEHAVIOR CATEGORY	PERCENT OF RECIDIVISM		
	3-YEAR ROSTER	PREVALENCE IN 1956	INCIDENCE IN 1956
Adult disorders	20.7	25.3	25.5
Crime (major and minor)	21.3	25.9	23.3
Mental illness (institutionalized)	19.6	23.9	29.7
Marital disorders			
Adult	19.4	30.8	19.7
Separated children	79.4	86.9	87.5
Child disorders	43.8	62.7	69.8
Delinquency, truancy, dropouts	46.8	66.8	57.9
Mental illness (institutionalized)	20.8	24.2	27.8
Total recidivist families	18.5	32.8	26.8
Total number of families	10,954	5,554	3,658

Of the recidivist families in the "adult disorder" categories, 54% are families with children.

These data make crystal clear that *"repeater" families are most highly concentrated in the two categories in which local therapeutic service also is concentrated.* They are responsible for 67% of the prevalence and 58% of the incidence of child disorders, and for 87% of both the prevalence and incidence of separated children.

From these facts, one might argue that it was a lucky accident which focused the community's therapeutic attention on the very point where the symptoms of unsatisfactory social behavior most repeatedly erupt; or that there is less than convincing evidence of the therapeutic value of the community's hard-won services. Such fruitless arguments miss the real point: the high concentration of the total problem in recidivist families now gives a known and readily identifiable base from which to refocus community strategy, method and policy in order to put to better use the service already available to prevent and control a very substantial segment of the total problem.

Thus, in overall perspective we begin to see some of the community-wide characteristics of disordered behavior with which a budding epidemiological science must more effectively come to grips.

Annual incidence and prevalence rates of 29 and 44 per thousand families in the population measure, for the first time, the substantial importance of disordered behavior to community planning.

On the surface it reflects a mixture of acute and chronic conditions with their respective volume and cost apparently in reverse relation to each other. Many signs, however, indicate that much of the symptomatically acute condition actually is chronic —and costly.

Except for aging mental cases, disordered

behavior is a problem of youth and middle age. Although indigency is an important factor, the problem is not predominantly one of indigency. Neither in its totality nor in its symptomatic segments can disordered behavior stand in splendid isolation; multiple problems, multiple symptoms and multiple services are present in more than half the cases.

State services with a therapeutic intent are concerned primarily with adults, similar local services primarily with children. Taken together, they cover only 48% of the annual workload.

A small group of recidivist families, 1.7% of the population, account for 40% of all behavioral episodes officially dealt with. They are heavily concentrated in child disorders and separated children—the two main points at which the community now provides its therapeutic efforts. These facts about recidivism now should serve as a focal point in reorienting and reorganizing for better operative goals.

PATHOLOGICAL FACTORS

Intensive work with a small number of cases by the staff team of the project's Family Center was expected, among its several other purposes, to provide materials in greater depth about psychosocial pathological conditions in the multi-problem, or recidivist, families on which therapeutic services of the community now are so largely concentrated. In many respects this required plowing new ground. The general characteristics of disorganized family life have been described by sociologists, anthropologists and other scientists as well as by social caseworkers themselves. But rarely, if ever, has family symptomatology been classified and analyzed with any precisely significant relationship to the processes of diagnosis and treatment. The logical analysis developed in this and other CRA projects, while obviously leaving much to be desired, represents an attempt to deal with pathological symptoms at three levels of accelerating relevance to diagnosis and treatment: namely, official symptomatology, disfunctional symptomatology, diagnostic symptomatology.

SELECTION AND GENERAL CHARACTERISTICS

As originally planned, the Family Center cases were to be selected from seriously disorganized families who reflected the severity of psychosocial pathological conditions responsible for a substantial portion of the total problem. There were two reasons for this: First, comprehension of pathological conditions is most readily derived from their more severe manifestations. Second, practically speaking, this was the group on which the community was spending a large part of its service money. In practice, recidivism, by definition an indication of multiple and multiplying problems, initially proved the easiest and we are now convinced the best characteristic by which to identify this group.

Originally it was hoped that these cases could be generally representative of all categories in the disordered behavior load. This depended on obtaining the cooperation of state and local agencies in providing case record material for the diagnostic workup and in implementing the formulated treatment plans. However, practical working plans with the state agencies did not eventuate, and for the large block of cases dealt with exclusively by the local courts and law enforcement agencies there simply were no casework records and no casework service. For these reasons the Family Center cases actually came from that part of the total load on which local

therapeutic services are focused. Child disorders (delinquency, truancy, school dropouts), or "separated children" were present in all but 38 of the 231 families.

Of the 231 families eventually worked up by the Center 201 were recidivist. Although not a perfect random sample of all recidivist families with children, they covered 16% of all those where any episodes occurred in 1955 and 1956; and they covered 22% and 25% respectively where episodes occurred in the categories of child disorders (juvenile delinquency, truancy, school dropouts) and separated children.

The proportion of these families who were also indigent, 46%, was higher than in the total load; the other 54% presented disordered behavior problems only. Both parents were in the home in 67% of the families; the mother only in 29%; the father only in 2%; both were out of the home in 2%. The heads of only 7 families were under 25 years of age; only 15 were over 55. The heaviest concentration, 113 or 49%, was in the 35 to 45-year age group. The average of 3.4 children per family is somewhat larger than the average for the general population.

OFFICIAL SYMPTOMATOLOGY

The truest and easiest identification of symptomatology in these families is by means of the official categories by which disordered behavior is defined. Although these families were served primarily on account of their children, the families themselves presented problems from all the officially defined disordered behavior categories—an important consideration in planned effective therapy.

The heavily weighted multi-problem characteristics of the two psychosocial disorders involving children, toward which the local community now directs the main stream of its therapeutic effort, are apparent from Table 4. Delinquency was a problem in 162 of the 231 families; 66 fami-

TABLE 4

Problem distribution among 231 Family Center cases

BEHAVIOR CATEGORY	NUMBER	PERCENT
Child disorders	168	73
Delinquency	162	70
Truancy	24	10
School dropouts (non-economic)	50	22
Mental illness (institutionalized)	3	1
Marital disorders	153	66
Divorce, desertion, separation	72	31
Separated children	87	37
Adult disorders	116	50
Adult misdemeanors	43	19
Abuse, neglect, nonsupport, etc.	30	13
Major and minor crimes	23	10
Mental illness (institutionalized)	19	8

lies presented problems of truancy or school dropouts or both. But in only 22 (10%) of the families was delinquency the only problem, and in only 5 (2%) were the school disorders not combined with delinquency. There were 87 families where children were separated from their own homes; in only 10 (4%) was this the only problem. These multiple characteristics explain the fact that 49% of the families were currently receiving service from four or more agency programs at the time of the Center's diagnosis—some from as many as 12.

The chronic nature of these episodes is evidenced by the fact that 60% of the families in which delinquency was a problem had been known by some official agency at least two years before the Center's diagnosis, and 30% had been known five years or more.

Perhaps the most significant deduction from the dispersion of all categorical disorders throughout these families is the impressive testimony given to the need for a family diagnosis and treatment plan, even though initial concern may be primarily with the children.

DISFUNCTIONAL SYMPTOMATOLOGY

More perceptive and of greater utility is a classification of symptomatology developed by the Family Center based on the way and degree to which these families were performing certain functions expected of them by society. Among such functions three were judged essential to successful social living:

- Marital functions: basic compatibility and helpful reciprocity between the male and female partners in all aspects of the sexual, domestic and social interpersonal relationships.
- Child-rearing functions: the bearing and rearing of children in a relationship conducive to physical well-being, emotional development, socialization and education.
- Economic functions: the adequate production and management of income.

Disfunctioning of course is the opposite of successful functioning. Inherent in this classification is the assumption that failure in any of these functions has a pathological or at least an unsatisfactory impact on not only the family as a whole but the behavior of the individual adults and especially the children.

It was the judgment of the Center staff that in the 231 families substantial failure to perform these functions was present in the proportions shown in Table 5.

In view of the community's concentration of therapeutic service on the problems of children, the outstanding fact is that in 98% of these families there was parental failure in performing the child-rearing functions. Of no mean significance is the corollary fact that in a substantial portion, 39%, the two parents did not get along with each other. In many instances their frustration, derived from dissatisfaction with their own sexual and personal relationships, was "taken out" on the children. The smallest proportion of failures (25%)

TABLE 5

Family Center cases: family disfunctioning

AREA OF DISFUNCTION	NUMBER	PERCENT
Child-rearing	227	98
Marital	91	39
Economic	58	25
One or more areas	231	100

was in the economic functions of income production and management.

Impairments. Correlated with these failures in family functioning were a series of impairments in the adult partners—in their moral and social standards, in the structure and setting of the family, and in their marital history—which were believed to be related to the etiology of their failures in functioning.

Such impairments in the adult partners believed to correlate with family functioning included: 1) serious physical disability, mental deficiency, psychotic or prepsychotic conditions; 2) a hostile, amoral attitude toward social laws and customs, and the encouraging or condoning of antisocial acts by the children or other members of the family.

Structural impairments to family functioning included homes broken by divorce, desertion or separation and the two characteristics of plural marriages (when one or both partners had been married previously and when there were children of these previous marriages in the current home).

These different types of corollary impairments were distributed through the 231 families in the proportions shown in Table 6.

TABLE 6

Family Center cases: individual and family impairments

TYPE OF IMPAIRMENT	PERCENT
Adult impairments	
Intrinsic (physical and mental)	36
Social (negative toward authority)	38
Family impairments	
Family composition	39
Previous marriages	58
Children of previous unions in home	47
Total	76
One or more listed impairments	93

Presumably serious mental conditions appear as a contributing factor in 23% of the parents, although it was found among both adults and children in 29% of the families. Mental deficiency was present in only 3% of adults and 5% of the families. In relatively few of the cases was physical illness of a disabling nature.

The Center staff believe, however, that two symptomatic impairments are of primary significance in family disfunctioning.

The first is the inability of parents to accept social standards as they are authoritatively expressed through established law and custom, their tendency to condone, often encourage, illegal unsocial behavior by other members of the family.

The second is to be found in plural families—especially those where children of both the present and a previous marriage are in the home. In these families the husband must function as a father for his own children and as a stepfather to his wife's children. The mother, on her part, not only has special feeling for her own children, but as stepmother to her husband's children is faced with a new set of values, not only in relation to different sets of children but to her husband. The readjustment facing all family members under these complex circumstances could tax the best integrated personalities. Obviously, the best integrated adults seldom head these recidivist families.

With this emphasis on the pathological significance of disfunctional symptomatology it is not surprising that the staff of the Family Center—representing the composite skills of social casework, psychiatry and psychology—agreed that "the parents of these children had grossly failed to realize their own capacity for social adjustment

during the developmental sequence of their own childhood. As a result they frequently are so preoccupied with their own chronic personal problems and marital struggles that they are unable to offer their children the necessary minimum of attention and care; they do not function as parents in any real sense . . . interpersonal relationships had been severely disturbed over a long period; processes of observable disorganization within the family often was of long standing . . . their children in varying degrees are seriously deprived and damaged emotionally and they become ill equipped to achieve a reasonably good personal adjustment. *Consequently these children tend to develop into adult persons whose potentiality for successful parenthood is severely limited.*"

DIAGNOSTIC SYMPTOMATOLOGY

The thought that distinctive patterns of family behavior can be identified, that they recur over and over again in the cases which come to social agencies, is not new. Behind that thought is the hope that identification of these patterns would mark a great step toward more precise diagnostic thinking and give clearer clues for etiological research. It was partially to try to identify these symptomatic groupings that the concurrent CRA research project referred to earlier in this report was launched, to produce materials relevant to family diagnosis and treatment.

In the later processing of these materials the concept of a basic norm of family behavior began to take form and shape, from which there were believed to be pathologically deviant family patterns. Each of these deviants is conceived to be identifiable by distinctive syndromes of reasonably precise symptoms of behavior. They also are believed to represent a continuum toward decreasing capacities to master the emotional and practical tasks of everyday living. These pathological types had emerged in a sufficiently clear diagnostic form toward the close of the San Mateo project to make possible a recasting of some but not all of the data used in analyzing the 231 cases.

The four pathological family types may be characterized briefly as follows:

Using Type 1 as the "normal" family, Type 2 is the anxiety-ridden family, beset primarily with internal emotional difficulties. They are often aware of their trouble and tend to seek help from the voluntary social agencies and mental health clinics. However, they do not tend to act out their emotional difficulties in behavior of which the community must take notice. Consequently, they rarely fall into the categories of disordered behavior with which this report is concerned.

Type 3 is the socially ineffective and unstable family. Generally they mean to conform to society's requirements but lack the capacity to do so. They are likely to follow a short-sighted "live it up" policy. They try to solve their difficulties by default—by running away from them. Thus their behavior is not aggressively antisocial but takes the form, in adults, of desertion, non-support or neglect, and in children of running away, truancy, begging and similar delinquency.

Type 4 is the parentally irresponsible family. In matters of support, income management and adult behavior they tend to be socially conforming and frequently quite effective. They do not break up their marriages, despite failure in their sexual relationships. In their overt behavior, what stands out sharply is their attitude toward their children and their way of bringing them up. This manifests itself in emotional exploitation of the children rather than

neglect, and reveals great disfunctioning in child-rearing. These are the parents who tend to blame the school for their children's problems, which are manifested in truancy, dropouts, extreme aggression toward other children, sexually deviant behavior and stealing.

Type 5 is the nonconforming, hostile family. These families have an aggressive disregard for the social codes and requirements of the community. Marital relations often mean exploitation of the partner. In families where the father is the dominant personality he is likely to encourage and promote antisocial activity. Where the mother dominates there is often open defiance of law and school authority intervention. Adult behavior is characterized by exploitation of others, crimes such as embezzlement, grand larceny, burglary and incest. Among the children, stealing and sexual promiscuity are common. This is the type of family in which psychoses in parents and children are most frequently found.

It should be said that the staff of the Family Center found no great difficulty in identifying these basic patterns among the 231 families. They fall in the following proportions: 3% Type 2; 33% Type 3; 32% Type 4; 29% Type 5. Of the 231 families, 3% were not classified.

Type 2 is so close to "normal" behavior that it did not stand out in any significant fashion among these seriously disorganized families, and was not expected to do so. Table 7 shows, in terms of the three main types of family disfunctioning developed by the San Mateo staff, the distribution among the three more severe pathological types.

Although failure in child-rearing is seen to be a common symptom of all family pathology, this expresses itself in particular and distinctive ways in each type which are not reflected by this table. Marital

TABLE 7

Family Center cases: distribution of types of family disfunctioning among three pathological groups

AREA OF DISFUNCTION	PERCENTAGES		
	TYPE 3	TYPE 4	TYPE 5
Child-rearing	99	99	97
Marital	46	24	51
Economic	29	8	37

disfunctioning appears somewhat less in Type 3 families than in those of Type 5, but there are further distinctive symptomatic expressions, again not reflected in this table. For example, it is characteristic of the Type 4 families that the parents do not overtly manifest their marital difficulties and that the marriages do not break up. Economic disfunctioning is greater in Type 5 families than in either of the other two severe pathological types. Type 4 families show comparatively less economic and marital disfunctioning; indeed a tendency toward disfunctioning exclusively in child-rearing is the distinctive characteristic of this class.

In summary, each of these three approaches to the classification of symptomatology has its own distinctive values. Taken together they indubitably portray a constellation of severe pathological processes at work in the personalities of the adult partners—in their interpersonal relationships, in the discharge of their responsibilities toward their children and in the newly forming child and adolescent personalities, who ultimately will become the parents of another generation. Thus the intensive diagnostic workups of the Family Center served the first purpose in portraying a picture of pathological depth, complexity and distinguishable variety.

In the remaining sections we turn to materials resulting from other purposes which the Family Center's intensive work was designed to serve—as a laboratory to create and test methods for:

- Classifying cases by rehabilitative potentiality and related levels of treatment.
- Systematizing more effectively the basic therapeutic processes of family diagnosis, treatment formulation and execution, prognosis and evaluation.
- Coming to grips with problems of integrating services.

POTENTIALITIES

This picture of pathological complexity and severity gives a dim view of the potentiality for preventing further depreciation of the community's cultural standards and values by these 231 families.

In the light of experience, however, members of the staff of the Family Center concluded with a brighter outlook: "The final psychosocial evaluation revealed more potentialities for constructive service than might otherwise be thought to exist. With the most difficult family situation it cannot be expected that marked internal change can be achieved. Nethertheless, it is possible to work with even these families in such a way that the impact on the community is modified."

CRITERIA

A major undertaking of the intensive casework activities of the project was the attempt to devise a means for precisely measuring those possibilities. Operationally, this effort was concentrated at two points: at the time of initial diagnosis the Family Center staff made a prognosis or prediction as to whether the cases could "improve," "not change," or "deteriorate." At the conclusion of the project each case was evaluated to determine what actually had happened.

The crux of the matter, of course, was the development of precise criteria that could be used uniformly as a basis for both prognosis and evaluation. It cannot be said that the results were wholly satisfactory. Nevertheless, two sets of criteria did begin to cut through the complex issues involved in evaluating behavioral change in relation to movement toward defined goals—heretofore a morass of personal predilections and conjecture.

Obviously, the underlying base from which improvement or deterioration in these recidivist families must be measured is whether or not they produce more or less disordered behavior. This is subject to objective measurement, not personal judgment; to reduce such behavior is the reason the community provides money to its agencies for therapeutic services.

Episodes. Therefore, establishing a first set of criteria for measuring change in these families, the project staff decided to use one episode by one person in any category as a statistical unit for episodic criteria. If at the time of diagnosis three members of the family were involved in three episodes in any of the categories and at evaluation only two members had been involved in two episodes in the interim period, the situation had improved. In reverse, if four members had been involved in four episodes, the situation had deteriorated. If the same number appeared at evaluation, there had been no change.

Although the reduction of incidence and prevalence is an ultimate goal, exclusive use of these criteria as a means of measuring progress or the lack of it had certain

limitations when applied in this project. The project was of relatively brief duration: 15% of the cases were known six months or less; 31% six to twelve months; 54% twelve months to 18 months. While episodes of delinquency in the same family may occur quite frequently, children separated from their own homes are likely to remain in foster homes or institutions for fairly long periods. Episodes within the latter category and others involving more chronic family conditions were much less likely to be repeated during the project period. Again, while a delinquent child on probation for six or twelve months is free in the community and actually may commit further delinquencies, these frequently are not officially reported. Unfortunately, also, a project covering such a short period can throw relatively little light on the "frequency cycles" of recidivist episodes; on ways in which the life cycle affects the repetitive impact of recidivist behavior; on recidivist "weighting" which should be given to cases under long-term and episodic care. Criteria developed in the project mark only the beginning steps of what inevitably always is a long road toward the precise refinement of objectives, indices and devices.

Diagnostic Judgment. Therefore, a second set of strictly diagnostic criteria were devised. These were based on the presence of the main factors believed to have the greatest etiological significance in connection with symptomatic behavior: family disfunctioning in the child-rearing, marital and economic areas; adult physical and mental impairments; plural marriages; negative social attitudes. A separate judgment was made about each factor and their several subclassifications. The key result, however, was a net assessment (that is, a diagnostic judgment regarding improvement, lack of change or deterioration in the total family situation). This net assessment was first made as a prognosis and, at the end, as an evaluation. At both points heaviest weighting among the several factors was given to the performance of the marital and child-rearing function.

CHANGE AT EVALUATION

Despite the discrepancies in the two criteria (see Table 8), each gives impressive confirmation to the Family Center staff's general conclusion that there were "more potentialities in these families than might otherwise be thought to exist." However, as we shall see, in a special group amounting to about a fourth of the 231 cases the whole therapeutic process was conducted under the relatively most favorable circumstances; these show a 59% improvement based on diagnostic judgment, in contrast

TABLE 8

Family Center cases: changes at evaluation

	IMPROVEMENT		NO CHANGE		DETERIORATION	
CRITERIA	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Episodes	146	63	60	26	25	11
Diagnostic judgment	76	33	131	56	24	11

to the 33% average for the whole, which is nearly equal to the improvement indicated by the episodic criteria.

Improvement in severely pathological types of families referred to in the preceding section were evaluated in the following proportions, confirming the belief that these types reflect pathological levels of increasing severity: according to diagnostic judgment, 41% of the Type 3 families improved; 33% of the Type 4 families, 19% of the Type 5 families.

Two further factors illuminate the conservatism of the staff's conclusion. These evaluative data relate to family members whose behavior already had become a matter for official community action. The first accrues from the fact that systematic family diagnosis identifies other members who although not yet in official trouble are likely to become so. This affords a telling opportunity for precisely focused preventive intervention which is not reflected by the evaluative data in Table 8.

In the 231 families there were 423 adult family heads and 796 children under 18. During the project 572, or 47%, of these family members were involved in disordered behavior episodes. But it was the diagnostic judgment of the staff that an additional 181 were likely to become involved—a 32% increase. Table 9 shows the number of adults and children in this group.

TABLE 9

Estimated additional future involvement in disordered behavior among Family Center cases

FAMILY MEMBERS	INCREASE	
	NUMBER	PERCENTAGE
Adults	53	22
Children	128	39
Total	181	32

Further, it will be remembered that slightly more than half of the 231 families were involved only in disordered behavior; slightly less than half were also indigent. In the former group, 30% more of the adults and 29% more of the children were believed headed for trouble; in the latter group, 17% more of the adults and 49% more of the children were believed likely to become involved in disordered behavior episodes.

Most of these indigent families were receiving aid to dependent children through the welfare department. While there are fewer adults in these ADC families (by definition, one parent must be missing or disabled), this relative concentration of potential delinquencies, truancies and school dropouts in this single administrative unit has obvious implications for preventive planning.

The second factor giving a conservative tinge to the staff's conclusion regarding potentialities for improvement lies in the degree to which the treatment plans conceived by the Center were carried out. All prognoses assumed that the treatment proposed would be effected. Initially, as indicated, it was expected that they would be carried out by the agency with chief responsibility for the case. In practice this did not happen. The Center staff, no less than the agency staff, were confronted with new problems of adjustment in learning to perform their respective roles in the function of integrating services. Standard loads of 75 cases per worker, fixed policies regarding episodic case closings, and many other factors made necessary a shift in project operation early in 1956. With an appropriation from the Board of Supervisors, matched by additional funds from the Rosenberg Foundation, three new case-

workers were employed and attached to the three agencies dealing with the bulk of the community caseload. These and two other workers supplied by the agencies were assigned exclusively to project cases with clear understandings regarding smaller caseloads and flexible policies.

Of the 231 Family Center cases, 150, designated as A cases, were processed in accordance with the project's original policy; the other 81, designated as B cases, were carried by the five assigned workers. By agreement, treatment plans were undertaken in all 81 B cases, although fully executed in only 49. Of the 150 A cases, however, treatment plans were undertaken in only 35%, fully executed in only 6%, partially executed in 29%. Thus in 65% of the A cases, the treatment received presumably was not influenced by the Family Center's diagnosis, but given in terms of the usual and traditional practices of the agency. In other words, these evidences of rehabilitative potentialities were present, despite the fact that a full head of treatment steam was directed toward only 57% of the total 231 families.

PROGNOSTIC ACCURACY

From an administrative standpoint, prognosis or prediction holds the key to a more efficient use of staff resources. It should identify cases with the best potentialities for improvement, indicate the levels of casework skill and of any specialized resources needed to achieve these potentialities, and furnish a basis for selective assignment to workers with skills and capacities best matched with the needs in each case. Obviously, however, prognosis offers such a key only if it can be achieved with reasonable accuracy.

In the total of 231 families, the case-by-case matching of prognosis with evaluation shows that, using episodic criteria as a basis, 65% were accurately predicted, 35% incorrectly predicted. The reverse was true—35% perfect, 65% incorrect—when diagnostic judgment was used as the criteria. Again, however, prognostic results in the 81 B cases were much more accurate than in the A cases, when the judgmental criteria were used (see Table 10).

TABLE 10

Accuracy and error in prognosis for A and B cases

CRITERIA	PERCENT ACCURATE	PERCENT WRONG
150 A cases		
Episodes	63	37
Diagnostic judgment	21	79
81 B cases		
Episodes	69	31
Diagnostic judgment	62	38

Among a variety of explanations that may be offered for the difference in degree of accuracy of diagnostic judgment between the two groups, two may be noted: Prognoses in the A cases were based on data in the agency records (that is, on the kind of data which the agencies normally have at their disposal). In the B cases the worker had direct contact with the family, could get all desired data and analyze them in terms of first-hand knowledge of the personalities involved. Second, most of the A cases were diagnosed and prognosed in the earlier stages of the project when the Center staff itself was learning to understand the concepts and processes involved. Most B cases, on the other hand, were prognosed at a later stage when the staff as a whole had more experience behind it.

TABLE 11

Structural treatment objectives recommended for 231 Family Center cases

STRUCTURAL OBJECTIVES	TOTAL	PERCENT
Maintenance or reestablishment of family	142	62
Emancipation of one or more children from family influence	47	20
One child	42	18
Two children	5	2
Dissolution (permanent removal of children from parental influence)	34	15
Standby services, ameliorative (dissolution or emancipation desirable but not at present feasible)	8	3
Total families	231	100

TYPES OF TREATMENT RECOMMENDED AND PROVIDED

Against the diagnostic perspective of pathological conditions in these families, it can well be understood that discussion of treatment plans in the Center's staff conferences usually focused on the issue of whether to maintain or break up the family; if the latter, the question was to what extent and degree. Involved in this issue were realistic questions about the types of specialized skills and services needed both to accomplish this structural objective and to treat pathological factors identified in the family as a whole and in the individual members.

Structural Objectives. Four different levels of structural objectives were defined and recommended for the 231 cases, as shown in Table 11.

This essentially registers a "structural decision" which caseworkers, judges, and others long have been making, more often on an administrative "off the cuff" basis than on a diagnostic and prognostic basis. Here, however, these decisions were systematically recorded and related to diagnosed pathology and to ultimate outcome.

The diagnostic quality of these decisions is indicated by the fact that the declining sequence of opportunities afforded to keep

TABLE 12

Distribution of structural treatment objectives recommended for three pathological groups of families

TYPE OF FAMILY	PERCENTAGE OF TOTAL IN EACH TYPE OF FAMILY			
	MAINTENANCE	EMANCIPATION	DISSOLUTION	STANDBY
Type 3	72	17	7	4
Type 4	61	31	8	–
Type 5	46	13	33	8

the family wholly or partially intact follows closely the increasing sequence of pathological severity reflected by the three family types, as shown in Table 12.

In Type 5, the hardened, aggressively antisocial, often amoral family, complete and permanent removal of children from all family influences was recommended more often than in the others, as offering the only possible hope that the children may be brought up to travel a different road from that taken by their parents. Clearly, in these families the more quickly this is done, the better.

In Type 4 families the marriage itself seldom dissolves and the parents are usually economically self-sufficient and often well-regarded socially. But they make their children suffer for frustrations in their own sexual and interpersonal interrelationships. Here then, the most frequent solution—especially for older children already involved in disordered behavior—is their emancipation by temporary or quasi- permanent removal, but without completely severing ties and contacts with the family home. These families too, it should be remembered, require the maximum of therapeutic skill in dealing with problems of interpersonal relationships. These parents do not wish to give up their children because of the social stigma involved. Great skill blended with the use of authority is required to bring about any redirection of parent-child behavior.

Although dissolution of the family *per se* often is all that can be done with Type 5 families, friendly, very practical helpful support usually is most needed by Type 3 families, in which the parents lack initiative and are the "leaners" of this world. Support, help and guidance enable them to perform their basic family functions, at least at a minimum level.

Therapeutic Service. Decisions affecting the structure of the family were made, of course, in connection with recommendations regarding therapeutic services.

The definitions behind most of the several classifications of Table 13 are generally obvious. However, no very precise criteria were developed by which to establish the presence or absence of therapeutic casework. The basic concept was of a quality of casework skill derived from formal professional training, in-service training, experience and competence to deal effectively with problems of interpersonal behavior and interpersonal relationships. It excluded casework competency limited to environmental manipulation. The classifications of "authoritative supervision" and "authoritative care" apply to probation and correctional services.

As perhaps might be expected, casework service was recommended in nearly all cases; the exceptions were 6 cases in which only authoritative supervision or care were recommended. Authoritative supervision came next in frequency of recommendation, a recognition of the realistic fact that in a very high proportion of these families one or more individuals had engaged in illegal activity. Financial aid, psychiatric service and medical service were found to be needed in a fourth to a third of all the families.

SOCIAL CASEWORK'S SIGNIFICANT ROLE

The significant fact, however, is that in 220 out of the 231 families casework service was bracketed with one or more of the other types of specialized services or resources. In the project operation, it became increasingly clear that success or failure in achieving integration of services (that is, acceptance and implementation of a com-

TABLE 13

Therapeutic services recommended for 231 Family Center cases

CATEGORY OF SERVICE	PERCENTAGE FOR WHICH EACH SERVICE WAS RECOMMENDED		
	TOTAL	A CASES	B CASES
Casework	97.4	97.3	97.5
Only	2.2	0.7	4.9
With supervision and care	92.6	94.0	90.1
With psychiatric	32.0	32.7	30.9
With medicine	24.7	20.7	32.1
Authoritative supervision	68.0	78.0	49.4
Authoritative care	29.9	38.9	13.6
Foster home	16.0	20.0	8.6
Institutional	16.9	23.3	4.9
Financial aid	31.6	21.3	50.6
Child care	4.8	4.7	4.9
Foster home	4.8	4.7	4.9
Institutional	—	—	—
Psychiatric service	34.2	34.7	33.3
Outpatient	20.8	20.7	21.0
Hospital	6.1	5.3	7.4
Residential	6.1	6.0	6.2
Correctional institution	4.8	6.7	1.2
Medical service	24.7	20.7	32.1
Outpatient	20.8	14.7	32.1
Nursing home	—	—	—
Hospital	2.6	1.3	4.9
Public health nursing	3.0	4.7	—
Other specialized services	8.2	10.7	3.7
Total cases	231	150	81

mon diagnosis and integrated treatment plan by all agencies involved in the case) rested in the last analysis with the social caseworker to whom the case had been assigned.

In historical perspective, the role of mustering, focusing and coordinating the special resource services needed by a particular family is not new to the casework profession. But this role is not now performed in relation to the totality of the family's problem; rather, it is limited to securing particular services conceived necessary to the defined function of the agency for whom the caseworker happens to be working. There is no uniformity in re-

cording and evaluating these processes as between agencies; indeed, seldom are they systematically recorded, analyzed and evaluated within the agency.

In the later years of its development the casework profession itself has tended to undervalue the process of obtaining and integrating special service resources designed to meet concrete needs and to dissociate it from processes presumed to influence the behavior of the client. Casework skill, however, rests on the ability to help the client meet the specific needs seemingly confronting him, with a perceptiveness that not only will improve his ability to utilize the resources necessary to this end but influence his general capacity for sustained social functioning. Thus, a considered conclusion of this project is that community planning for prevention and control depends in no small measure not only on the systematization of this basic integrating role but also on raising it to the level of community-oriented goals and procedures.

In the later stages of the project, as already related, caseworkers handling the B cases were doing so at a level of community responsibility accepted by the cooperating agencies. They were using systematic procedures evolved by the project. It is of interest, therefore, to compare their service recommendations with those of the A group. Both recommended casework in almost all instances; although the number is small, casework only was recommended for over twice as many B cases as A. Much less authoritative supervision and care were recommended for the B families, however; this was strikingly true for the two most expensive types of authoritative care—foster home and institutional. On the other hand, B cases were deemed to need considerably more financial aid and medical service.

There is great uniformity in the recommendations regarding psychiatric service. These recommendations, however, are heavily weighted by a need for psychiatric service in connection with residential treatment. In the overall count, psychiatric treatment was recommended for 62 cases; 25 of these, or 40%, were in connection with residential treatment. Care for children away from their own home was recommended in 81 instances; again, about 25% were for residential treatment with psychiatric service.

Table 14 at least suggests that both time and skill are required to find certain types of specialized service, to persuade the client to use them, and to implement their integration in a common plan. Because of the way in which the A and B cases were staffed, recommended casework service was implemented in a relatively small proportion of the former but in practically all of the latter. There are, however, significant similarities and differences in the implementation of other specialized services and resources. In several of the service classifications the number of cases was so small, especially among the B cases, as to have no value for comparative purposes, and these have been omitted from the table.

In general, services that are relatively easy either to make available or to persuade the family to use were implemented about equally in the two sets of cases—notably financial aid and hospitalization. There was considerably less activity directed toward getting the families under authoritative supervision in the A group, despite the fact that this involves episodes presumed to require legal and official action. Success was notably greater among the B cases in getting families to use psychiatric outpatient service; the same was true in a lesser but still striking degree in connection with medical outpatient services. Recommendations for residential treatment

TABLE 14

Provision of recommended service to 231 Family Center cases

CATEGORY OF SERVICE	PERCENTAGE OF RECOMMENDED SERVICE ACTUALLY PROVIDED		
	ALL FAMILIES	CASE GROUP A	CASE GROUP B
Casework	48.9	24.0	94.9
Authoritative supervision	80.9	75.2	97.5
Financial aid	97.3	100.0	95.1
Psychiatric service			
Outpatient	22.9	9.7	47.1
Hospital (inpatient)	64.3	62.5	66.6
Residential	none	none	none
Medical care			
Outpatient	75.0	45.5	100.0
Hospital (inpatient)	83.3	100.0	75.0
Other specialized services	21.1	18.8	25.0

accompanied by psychiatric service could not be carried out because none is available in San Mateo County.

SERVICE AND OUTCOME

It should be clearly understood that it has not been the purpose of this or any of the other CRA projects to test the effectiveness *per se,* of casework or any other kind of specialized service utilized by the community in its efforts to deal with psychosocial disorders. The primary purpose has been to devise means for better supporting and utilizing these professional skills. Any scientific effort to sharpen, refine and test them against case outcome, we are convinced, must be especially designed for that purpose and carried out in a well-controlled and integrated clinical setting, which this was not.

Nevertheless, by the accident of operational necessities, the project does have two sets of data about cases where treatment was largely carried out in the terms recommended by the Center, and those where it was not. There was a sharp distinction between the treatment service given A and that given B cases. All of the latter were treated by well-trained caseworkers carrying small caseloads and working under more direct supervision by the Center. Nearly all of the B cases received more casework service, in accordance with the recommended plan. They also received considerably less authoritative supervision and substantially more financial aid, psychiatric and medical service. Differences in outcome by the two sets of criteria are shown in Table 15.

Obviously the two sets of criteria are in disagreement at numerous points. On the one hand, it is quite clear that the Center staff found a consistent relationship among their net assessment of factors requiring change, the actual provision of services as

TABLE 15

Comparison of change by two sets of criteria, 231 Family Center cases

TYPE OF CHANGE	PERCENT OF EACH CASE GROUP	
	A	B
Improved		
Episodes	59	71
Judgmental	19	59
No change		
Episodes	31	17
Judgmental	66	40
Deteriorated		
Episodes	10	12
Judgmental	15	1
Total cases	100	100

they recommended it and their judgment at outcome. The B cases, where generally their recommendations were carried out, showed on the final diagnostic appraisal to have achieved a relatively high rate of improvement and a relatively low rate of deterioration. Conversely, the A cases, where service generally was not provided as planned, show a much lower rate of improvement and a higher rate both of deterioration and no change.

The episodic criteria also testify to high rates of improvement in the B cases—even higher than that indicated by the staff's diagnostic judgment. On the other hand, in reducing their actual involvement in disordered behavior episodes the A cases did not do badly either, although not quite so well as the fully serviced B cases. It follows logically that reviewed from the standpoint of repetitive episodes, the A families did considerably better in holding their own, and somewhat better in warding off deterioration, than was true when their progress, or lack of it, was diagnostically appraised.

In summary, it is clear from these comparisons that the project was not designed to test the effectiveness of treatment, and its data cannot be used for this purpose. But the data do, with some effectiveness, illuminate two points:

- First, they show the need for further research and active experimentation to devise more precise criteria by which to measure objectively "improvement," "no change" or "deterioration" in each family as it affects the community burden of disordered behavior, whether based on recidivism, length of care, cost or some combination of these indices.

- Second, they show the need for more precise guides which will tell community planners and administrators under what diagnosed circumstances it is profitable to provide in a particular family intensive high-quality casework and psychiatric skills.

Finally, it should be equally clear that this brief pursuit of the so far illusory relationship between therapy and outcome should not obscure or confuse the firm conclusion of the project that:

- There are real potentialities for improvement in the condition of these deeply pathological recidivist families—more than the project staff originally anticipated.

- The use of systematic processes for family diagnosis, prognosis, establishment of treatment goals, and integrated provision of precisely defined services and ultimate evaluation constitute the heretofore missing means of identifying, classifying and using appropriate service to achieve these potentialities.

• Social casework is the central ingredient essential to the implementation of these processes.

We now turn to a close inspection of the processes themselves, as developed by the project, and the problems involved in their application on a community-wide scale.

PROCEDURAL AND STRUCTURAL ISSUES

San Mateo has made firm plans for the permanent application of the philosophy, concepts and methods developed in the project. Its Board of Supervisors has taken the steps necessary to administer and finance the plan. The Rosenberg Foundation has given an additional grant to help bridge the transitional gap. CRA will assume a consultive role, with initial responsibility for a training program designed to induct all personnel concerned with the plan into its actual operation.

In taking these steps San Mateo has dealt in a practical way with the two main issues facing any community which wishes to shift the focus of its current service operation toward prevention and control. The first embraces issues of procedure. The second involves structuring these procedures through the intricate complex of the community's present agency organization, personnel and service policies. Of these, the first has prior importance. To think otherwise is to put the cart before the horse.

PROCEDURES

The basic processes developed in this and other CRA projects are neither foolproof nor easily adaptable to any agency or community wishing to use them. But although they need further sharpening on the grindstone of daily use and adaptation, both in concept and detail, to different settings and different circumstances, they are no longer completely experimental. The basic concepts have stood up and the specific tools are now usable if accompanied by careful training and close supervision of the people who are going to use them. These procedures as developed and used in this project are of two main types, which may be briefly described as follows:

Reporting. Systematic and uniform reporting by all agencies dealing with cases involving the problem as defined constitutes the wholly essential underpinning for any community program for prevention and control. It is equally essential that the reporting design be solidly embedded in the concept of the family as the unit in which all problems present themselves and to which all services are related. With anything less than a complete reporting system built on these concepts, the community will be attempting to deal with a problem whose proportions and interrelationships are unknown, unrecognized and misconceived.

As indicated earlier, in the initial planning study the 72 state and local agencies providing health, welfare or adjustment service to San Mateo County reported facts about all cases in their caseload during January 1954 on a uniform schedule designed for this purpose. From that point on the 10 agencies dealing with disordered behavior reported monthly their new cases on a short form of this same schedule. This was the first step in laying the foundation for a community-wide, family-oriented approach to the program issues involved in preventing and controlling disordered behavior.

The FURS Schedule. The Family Unit Report System card was originally developed

for the St. Paul study in 1948, and with subsequent modification and simplification it has been used in all three of the current CRA projects. It is so designed that all problems and service involving either the family as a whole, or specific individual, can be related and tabulated in terms of the family unit. These data include:

Family composition. The family is defined as consisting of a family head and all other persons in the home or temporarily absent who are related to the head by blood, marriage or adoption. Each person in the family is listed, showing whereabouts and relationship to the family head.

Problem. It was noted earlier that a common orientation in most welfare activity has been toward the provision of service as its chief goal rather than the solution of community problems. Thus it is of considerable importance that the schedule in the first instance report problems affecting the family as a whole and its individual members. These are classified first under broad definitions of dependency, ill-health and maladjustment; within these are reported more precise facts of dependency, indigent disability and disordered behavior, as defined in these projects. A comprehensive list of subclassifications covers such familiar problem categories as specified diseases, mental disorders, the public assistance categories, and so on.

Services. The main classifications of service used in the schedule have been identified in tables previously presented. They include financial assistance; casework; psychiatric treatment in its more usual settings (outpatient, hospital and residential); medical service in its appropriate settings; and authoritative supervision, similarly handled.

The statistical and reporting value of this card lies in the fact that both problems and services are classified. The accompanying definitions and instructions thus insure uniform reporting on a single card from all agencies, no matter how diverse their purposes and activities may be.

The roster. In the initial prevalence study in January 1954 data about some 2,900 San Mateo families currently known to adjustment services were assembled on the FURS schedule. This was the foundation of the roster. As a new episode of disordered behavior was reported for any one of these families, it was entered on the appropriate card. As episodes were reported for a new family, a new card was added to the roster. From this tool, most of the epidemiological data contained in this report were obtained.

The register. The FURS card, however, was designed for research, not operational purposes. As the project moves into its next phase, the card must serve an administrative purpose for a portion of the total flow of cases. CRA therefore has redesigned the original schedule to serve the purpose of a cumulative register. The additional items record:

- The family diagnosis and the principal factors deemed to be significant in connection with it.
- The services specified in the treatment plans.
- The prognosis for the family as a whole and for individual members.
- The evaluation in relation to the prognosticated items.

THERAPEUTIC PROCEDURES

CRA, it seems hardly necessary to point out, did not invent the classification of the

basic therapeutic processes of data collection, diagnostic formulation, treatment planning and execution, and prognosis. These processes were understood by the medical and other professions long before they began to be adapted to social welfare purposes. But all CRA projects have:

- Sharply differentiated between, and therefore helped clarify, the therapeutic significance of each step in the sequence.
- Shown how to use prognosis as an effective tool of case classification and case management.
- Insisted upon periodic evaluation as a stimulus to and check upon the validity and effectiveness of all other processes.
- Begun to structure and systematize these processes formally through the development of a case classification schedule.

The Case Classification Schedule. This tool was devised as an aid and guide to professional skill. Professional competence, and special orientation and instruction in the basic concepts and processes which it implements are requisite to its effectiveness. It is through this schedule that uniform data are made available for case analysis by the caseworker and supervisor. Through it also the sequence of steps in the therapeutic process are revealed for inspection. They become a matter of consciously formulated record. At present these steps, although always taken, are often done so without consciously formulated thought; if recorded at all they must be distilled for inspection, analysis and appraisal from a chronological descriptive record in which the essence and form are easily lost.

The case classification schedule now in use emerged from hard-wrought trial and error during the earlier stages of all three projects. Initial schedules were conceived in terms of the particular objective of each project; in the fall of 1956 these were consolidated into a single generic schedule which has been used since then in the Minnesota and Maryland projects. For operational reasons San Mateo did not shift to this consolidated form but continued to use two schedules previously developed—one for diagnosis, the other for prognosis. However, the generic schedule, revised and brought up-to-date in the light of the experience of the last 18 months, will now be introduced in the next phase of the San Mateo program.

In its present form the schedule is divided into four sections:

Section 1: Identifying information (basic information about family composition, marital status and history, particular data about individual members).

Section 2: Guides for the diagnostic workup (the client's application and reason for it; presence of adult disorders, marital disorders, parental disfunctioning, physical and mental health problems).

Section 3: Diagnostic formulation of the major psychosocial disorders affecting the family as a group and its individual members, as well as the individual and family strength that can be used in treatment process to influence adaptive capacity.

Section 4: Formulation of the treatment plan with specification of the services recommended and actually received.

Section 5: Prognosis in relation to the major psychosocial disorders specifically identified in the diagnostic workup and formulation; evaluation at a later specified date with respect to these same prognosticated factors.

The present schedule, as it has emerged, is not a perfect operational tool. Neverthe-

less, it already has demonstrated its usefulness and value. Experience in all three projects makes it crystal clear that a tool for guiding and recording systematic case analysis, case history and case management through these sequential steps is essential to the reorganization and reorientation of agency processes and procedures toward community prevention and control.

STRUCTURAL ISSUES

All issues involved in realistically structuring the application of these basic concepts to the community's ongoing program either arise out of, or are greatly complicated by, a well-known fact: Numerous agencies, with separate and often conflicting traditions, philosophies, objectives, procedures and personnel, are providing particular services in connection with particular symptoms of the total problem. Excerpts from a report written during the earlier stages of the project throw a colorful light on community organizational difficulties which generally are all too well recognized and understood:

"For the most part, agencies were pretty well convinced of the rightness of their existing programs, their own competence and the rightness of their established ways. The one problem everybody recognized was that they had too much to do. What they wanted, really, was someone to whom they could shift some of their load. . . . Some agencies see their function primarily as that of expediting a particular procedure defined by law or custom; others, as carrying out a process helpful to the individual in terms of his own expressed needs. . . . Salary scales and personnel requirements in some San Mateo agencies are among the highest in the state. Our project, however, puts a high premium upon professionally trained caseworkers. That can seem to pose a threat to the big majority of workers who have not graduated from a school of social work. . . . On the other hand, professionally trained workers have some tendency to regard their authority as ultimate and absolute. This tends to put them in conflict with specialized agency workers who are apt to regard themselves as having ultimate and absolute authority in their particular area of operations."

These comments were written when "everybody seemed to be in the act," before the community problem of disordered behavior began to take form and shape, before the focal points in policy, administration and personnel were clearly identified. These difficulties, intrinsic to both human nature and community welfare organization, still exist. But *who* must deal with them, and *how*, is now much clearer.

MAJOR RESPONSIBILITY

In San Mateo seven local agencies were providing service with a therapeutic intent to disordered behavior families with children. In 1956 they dealt in the proportions shown in Table 16 with the families in this therapeutic load.

TABLE 16

Annual therapeutic load

AGENCY	PERCENTAGE OF 1956 INCIDENCE
Probation department	50
Welfare department	25
School guidance department	17
Child guidance clinic Adult psychiatric clinic Catholic Social Service Family Service Society	18

There are, of course, duplications in these percentages. Almost all of the school guidance cases, for example, were also known to the probation department. But what immediately catches the eye is the dominating service responsibility of the two main public agencies—the probation department and the welfare department. The two departments spent $648,000 in 1956 for service in connection with disordered behavior families, and together were carrying nearly three-quarters of the load. The tax-supported adult mental hygiene and child guidance clinics and the voluntary Family Service Society and Catholic Social Service spent $162,000 but they were carrying only 18% of the therapeutic load. Obviously the large probation and welfare departments carry the dominant therapeutic responsibility for recidivist families who, it will be recalled, account for 87% of the annual incidence of separated children and 58% of delinquency, truancy and school dropouts. In 1956 there were a total of 721 recidivist families with children with incidents in these categories. The proportion of these families dealt with by the therapeutic services is compared in Table 17 with that of the 231 Family Center cases.

JURISDICTIONAL OVERLAP

With the probation and welfare departments so largely occupying the center of the therapeutic stage, it is important to try to clarify the way in which responsibility is divided between them. This is not too easy. In terms of the traditional functions legally assigned to them, the probation department must deal with all reported delinquent acts, but some of these are handled officially through the court and some are not. The welfare department is exclusively responsible for assistance; as we have seen, however, families receiving aid to dependent children are substantially involved in delinquent behavior. The welfare department places children in foster homes and institu-

TABLE 17

Distribution of therapeutic caseload in 1956: All recidivist families with children compared with Family Center cases

AGENCY	PERCENTAGE OF 721 RECIDIVIST FAMILIES WITH CHILDREN	PERCENTAGE OF 231 FAMILY CENTER CASES
Probation department	83	90
Welfare department	34	56
School guidance department	15	43
Child guidance clinic	8	—
Adult psychiatric clinic		4
Catholic Social Service		13
Family Service Society		5

tions; so also does the probation department.

Perhaps some of this overlapping activity might and should be eliminated, but under any circumstances the two departments will continue to deal with families who behave in a manner which sometimes brings them under the jurisdiction of one, sometimes of the other, and sometimes of both.

One must review these relationships from a perspective of time sequence. In any specific month the proportion of the total load of delinquent and separated children receiving service from the workers of both departments is not large. In January 1954, for example, the two departments were jointly active in only 9% of their combined loads. These cases represented an almost equal proportion, 17%, of the disordered behavior loads of each department in that month. These jointly-served families, it should be remembered, were recidivist families (that is, by definition they had been involved in more than one episode).

The picture changes when seen over a longer span of time. The 721 recidivist families with children who had episodes in 1956 were checked against the roster (which, it will be recalled, was built up from the January 1954 prevalence load plus all new disordered behavior families during the ensuing three years). Over this longer period the proportion that had been known exclusively by each department diminishes sharply. Many more in each departmental load had been known and received service from the other department within the total time period covered by the roster. Together they had known 697 of the 721, as shown in Table 18.

The general validity of this picture of departmental interrelationships is confirmed by even more comprehensive data from the Family Center's 231 recidivist families. These were checked, not only against the roster but from their all-time service history, for instances of service from the two departments. Data for this longer time span proved to be almost identical with that available from the roster.

Thus we see that 43% of these recidivist families were at some time known by and received service from both departments. Of those in the caseload of the welfare department only a handful failed at some time to come within the purview of the probation department. On the other hand, nearly half of the probation department's recidivist load were recidivist only within the two disordered behavior categories for which it is responsible—delinquency and truancy—and had received therapeutic service from no other agency.

The therapeutic significance of this exclusive responsibility is further revealed in Table 19, which shows how the three patho-

TABLE 18

Roster history of 697 recidivist families known to probation and welfare departments, 1956

RECIDIVIST FAMILIES	NUMBER	PERCENT
Families known to one or both departments	697	100
Families known to welfare department only	56	8
Families known to probation department only	340	49
Families known to both departments	301	43

logical types among the Family Center's 231 families were distributed between the two departments.

Clearly, the probation department has the primary responsibility for Type 4 families, which constitute the largest share of the cases known exclusively to the department. These are the families in which disordered behavior is mainly confined to the children, where socially conforming parents vent upon their children severe frustrations arising from their own pathological interpersonal relationships. These families require maximum skill and authority to redirect constructively their attitudes and social behavior.

The other striking fact is that 70% of the Type 5 families were known to both departments. These are families with hostile, aggressive, amoral parents, in conflict with the law, on and off public assistance rolls. For many of these families the only solution is quick and permanent removal of the children from all parental ties and influences.

San Mateo County's probation and welfare departments obviously hold the structural and operational keys to the redirection of the community's therapeutic service toward the goal of prevention and control. This redirection is possible only if means are developed to bring about a much greater measure of uniformity in objectives and outlook along with coordination in policies and procedures. Issues inherent in this necessity have by no means been resolved; nevertheless, a sound foundation now has been laid for doing so.

SAN MATEO'S SOLUTION

In the final stages of the project it became apparent that the main blocks to a common integrated and positive approach to the community's problem of disordered behavior were rooted in basic, long-accepted concepts and policies. There were, and no doubt always will be, plenty of the obstacles which stem from the uncertainties and instabilities of human nature, and the details of agency custom and practice, but as this project neared conclusion gradual shifts in basic thinking unblocked the path to a coherent plan. The project staff, its advisory board, the chief administrators and board members of the probation, welfare and school guidance units, the Board of Supervisors and county manager, each from his particular vantage point began to see:

1. That it was fallacious to assume that a preventive, therapeutic program could rest solely on the concept that if more and better service were provided the task would be accomplished. Rather was it necessary in the first instance to shift program thinking

TABLE 19

Pathological family types among Family Center cases served by probation and welfare departments

PATHOLOGICAL FAMILIES	PERCENTAGE OF 231 FAMILIES		
	TYPE 3	TYPE 4	TYPE 5
Served by probation department exclusively	38	61	17
Served by welfare department exclusively	11	7	13
Served by both departments	51	32	70

and emphasis from the humanitarian but negative concept of merely providing needed service, to the equally humanitarian but positive concept of solving the community's problems.

2. That it was equally fallacious to assume that more and better service depended solely on filling all budgeted casework positions with fully trained professional social caseworkers. This was an impractical objective short of the millennium. Graduate caseworkers were in short supply; in no foreseeable future could the Board of Supervisors implement such a policy even if it could afford to do so. Moreover, the services of trained workers already in the departments were not now being used to full advantage.

3. That the standard policy of annually budgeting for and using casework personnel on the basis of a formula assigning a uniform number of cases to each worker was likewise unsound. Under past policy agencies had consistently tried to lower the stipulated uniform caseload as funds and trained workers became available. But this policy, based on the two assumptions previously noted, was defeating its own purpose. It put off almost indefinitely the time when therapy by fully trained caseworkers carrying no more than 20 to 30 cases could begin. It further missed the mark in that it assumed (a) that all families presented problems equally difficult to resolve and had equal potentialities for resolution of their problems, and (b) that as of any given time all workers were possessed of equal capacity to help solve them.

4. That despite a general belief that the family should be related to the particular services provided by the probation, welfare and school guidance units, their service policies and therapeutic and recording procedures were not structured to implement this belief with any real therapeutic value.

5. That although a substantial proportion of the families in the agencies' loads were given service at some time in their history by all three units, the therapeutic outlook, policies and procedures of the units differed greatly and sometimes were in direct conflict.

6. That inevitably because of the distinctive responsibilities of the two largest units, all grounded in law and custom, neither of them were or could be equipped adequately to represent the community's broad interest in the total problem of disordered behavior.

7. Therefore, that to create a positive program for prevention and control through these departments, it would be necessary to:

- Develop systematic and uniform procedures for identifying and classifying cases by their potentialities for rehabilitation or improvement and the level and type of service believed necessary to achieve these goals.

- Reorganize personnel and caseload practice so that the department's best-trained and most skilled professional workers available now or in the future could be assigned to families which had been given priority because rehabilitative results were believed possible through skilled treatment service.

- For these cases at least, and ultimately perhaps for the total caseload, systematically structure basic therapeutic and recording processes to assure full consideration of family assets and capabilities in diagnosis, treatment and evaluation.

- Devise some structural scheme independent of, yet integrated with, the agencies carrying principal service responsibility, to represent the community's interest in the total problem of disordered behavior and

the successful carrying out of these basic policies and procedures.

SAN MATEO'S PLAN

As there came to be a general meeting of minds about the fallacies of the past and the needs of the future, broad agreements about what should be done were developed. As of January 1958 this took firm and practical form through resolutions and actions of the Board of Supervisors. The program thus set up will go into effect as rapidly as administrative changes can be made and personnel either reassigned or obtained to man it. Budgets have been approved on the assumption that it will take about eighteen months to perfect a fully staffed, well-oriented, smooth-running operation. This assumption is in line with CRA's own project experience.

The main elements in the program are as follows:

1. New special diagnostic and treatment units will be organized in both the probation and welfare departments. The county school department's plans are not yet completely firmed up; in all probability they will involve better adjustment and referral service but not full-scale diagnosis and treatment.

2. The new units in the two large departments will be staffed by well-trained caseworkers carrying small, flexible loads of a size to be determined and adjusted by experience. The present budgets provide for a beginning staff of five workers and a superviser in each department. Additions will be made as dictated by demonstrated experience, funds and available personnel.

Initially at least, these units in the two departments will concentrate on recidivist families—to be screened, selected and assigned on the basis of rehabilitative priorities for full diagnosis and treatment, to the staff of the unit. Presumably the screening and diagnostic process may later be applied to all new nonrecidivist intake, if experience warrants it.

3. Both units will use the basic processes of family diagnosis, treatment formulation, prognosis and evaluation, as developed by CRA. The case classification schedule is being revised as a common instrument for guiding and recording these processes. A special training and indoctrination process for which CRA initially will be responsible is now in preparation for personnel in all administrative echelons concerned with the operation of these units.

4. A new and independent committee, the Family Service Coordinating Bureau, has been set up by the Board of Supervisors, to be directly responsible to that body and its county manager. Membership on the bureau's board will include the executives of the three agencies and two laymen. If, as seems likely, the executive of the newly constituted consolidated mental health services is appointed to the bureau, an additional layman will be appointed. The bureau is charged with the following functions:

- Maintaining a reporting system and the roster needed to identify disordered behavior families, and providing community-wide data on the scope of the problem. As part of this, a register will be maintained to record essential data about the action taken on all cases selected for service by the special units.

- Setting standards for staffing, for processing the therapeutic service provided by the two units and for integrating these services in families where the agencies are or have been jointly involved.

- Assisting the agencies in planning, installing and improving the standard classification procedures developed by CRA during the project.

- Providing training, orientation and continuing consultive service to the agency units on all phases of their operation.

- Providing for, sponsoring and reporting the results of a systematic evaluation of case progress at periodic intervals.

The board of the Family Service Coordinating Bureau will be assisted by a professional staff consisting of a director, a social casework consultant and a statistician, with the necessary clerical and office assistants.

The estimated budget for the 18-month period totals, in round figures, $130,000. The bulk of this will come from county funds, partly through the reallocation of funds already budgeted. The Rosenberg Foundation, however, has made an additional appropriation to the county to assist it through this transitional period.

In conclusion, the writers want to emphasize that the structure of this plan was designed for San Mateo in cooperation with San Mateo's community and agency leaders, and that this report does not presume it to be adaptable in its detail to any other community.

At the same time, we are convinced that the issues from which the plan emerged are common to all communities, and that the principles articulated in their solution have wide applicability.

The factors of greatest strategic importance are these: a clear definition, identification and analysis of the community problem of disordered behavior; the avowed orientation of program objectives toward prevention and control; the common systematization of basic recording and therapeutic process toward this end by the agencies mainly responsible for the program; the guidance of these processes and the evaluation of performance by representatives with broad community interests. From these, the form and shape of a more positive, workable, preventive program can emerge in any community with leadership sufficiently dedicated and competent to undertake it.

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An evaluation of a mental health week program

Last April 28 to May 4 under the aegis of the National Association for Mental Health the nation observed the ninth annual Mental Health Week. Throughout the country, state mental hospitals, often in conjunction with local and state mental health associations, conducted programs to bring to the public greater understanding of the number one health problem in the U. S. Many state mental hospitals were particularly interested in widening such understanding to include appreciation of their role in relation to mental illness and health, and thus to bridge the gap between the treatment center and the community. Having special goals in mind for these programs, and realizing the tremendous expenditure of the hospital staff's time and energy involved, it becomes essential that exploratory evaluations be undertaken to assess the value and structuring of specific Mental Health Week programs conducted at representative mental hospitals.

The present paper describes the evaluation of a Mental Health Week program at a midwestern state hospital. This is a large (1,500 bed) hospital that is over 40 years old, located three miles from a town of 5,000. The nearest city of any size is 120 miles away. Once a year, during Mental Health Week, the public is formally invited to visit the hospital. This was the fifth year for the program at the hospital; over 15,000 visitors have attended previous programs. This presents the staff with an

The seven co-authors of this paper were all on the staff of Larned State Hospital in Kansas. Their study was a project of group research in the hospital's department of clinical psychology. They wish to express their appreciation for cooperation extended by other departments, by the hospital's Mental Health Week committee and by the visitors.

opportunity to show the public at first-hand what is being done and what part they may play in supplementing the hospital treatment program. There also exists the possibility of changing some rather strong prejudices and attitudes that may be held about mental illness, the physical plant of the hospital, the type of care given to the patients, and the composition of the hospital staff.

From the standpoint of the staff, an analysis of Mental Health Week is valuable, as considerable time and energy is devoted to staging the 4-day program. For many individuals and departments the hospital literally "stands still" during Mental Health Week. Innumerable committees are busy making displays, planning panel discussions, coordinating the movement of staff and visitors. It would be difficult to estimate the time that is spent by the staff in preparing for Mental Health Week. The figure of 1,000 man-hours of time of the professional staff seems on the conservative side. (It is interesting to note that those concerned with the program at this hospital, and at many other state hospitals, are almost exclusively the professional personnel.) In addition, there is the time spent during the 4-day program when almost all staff meetings and other activities of the professional staff are curtailed or cancelled.

Hence, the program is important to the hospital administration in terms of the large expenditure of funds and the time of the professional staff. It is of interest to the hospital authorities to know whether this outlay is justified by the results of the program. If the visitors arrive convinced that the hospital is "like a prison" and depart with the same feeling, and no interest in problems of mental health is generated, it might be more fruitful for the staff to devote itself exclusively to the welfare of the patients rather than in abortive attempts to educate the public. There exists the possibility that educating the public might better be accomplished by lectures to clubs or school groups. State hospital grounds are rarely known for their attractiveness and might not be expected to be the most effective locale for effecting positive attitude changes.

In addition, the Mental Health Week program constitutes one of the few links between the social systems of the hospital and those of the surrounding communities. As Belknap [1] has shown in his analysis of a Texas hospital, there may be only infrequent social contacts between the professional staff of the hospital and the townspeople. Such contact most frequently occurs between the non-professional employees of the hospital and the townspeople of similar status. A considerable proportion of the townspeople, living only a few miles from this hospital that is named after their own town, have never in their lifetime visited the institution. By about half of them it is still referred to as the "State Farm" or in less euphemistic colloquialisms.

Many visitors frequently remark that the mental hospital strikes them as a "little city" with its own housing, fire department, farm, barber shops, etc. Some of this can be traced to the relative geographic isolation of many state hospitals and the need to have all facilities close at hand. It also highlights the appearance of autonomy or self-sufficiency of the hospital, which may discourage or at least impede communication between the two social systems. Visitors' days during Mental Health Week are one of the few times when the barriers become permeable and passage is encouraged from the town system to the hospital system. This does not necessarily

[1] Ivan Belknap, *Human Problems of a State Mental Hospital*, New York, McGraw-Hill Book Co., 1956.

mean that passage is encouraged in the reverse direction: for in the present situation, there is no increase in the number of staff-town contacts in the locale of the town system (as would be the case with an intensive program of community talks during Mental Health Week).

In the case of the present Mental Health Week program, the only chance for attitude change occurs within the geographic setting of the hospital grounds. Hence, it is conceivable that any barriers within the town system (such as strong feelings about association with mental patients, or beliefs about the hospital personnel) may remain relatively intact. That a person chooses to attend a Mental Health Week program may be more a manifestation of his curiosity about what goes on at such a hospital than an expression of deep-rooted interests in problems of mental health or in bridging the gulf between the two social systems. In other words, attendance *per se* may connote many things, and more precise analysis is necessary to determine the initial attitude and any changes that may occur as a result of the Mental Health Week program.

PROCEDURE

The Mental Health Week program was spread over a 4-day period. On each day the program was tailored to a particular group of visitors. Other individuals, such as townspeople, wives of clergymen, etc., also attended on each of the days. The total number visiting the hospital, and the number included in the sample tested, are presented in Table 1. Column 1 shows the total number of visitors coming to the hospital. Column 2 gives the number of visitors in the categories which were to be tested (*i.e.*, on Students' Day, it was decided to remove from the sample all teachers and bus drivers who had accompanied the students; on Clergymen's Day, it was decided to remove the group of clergymen's wives and YMCA secretaries. Column 3 gives the total number of visitors in each day's sample.

The samples were randomly selected (not volunteers) from the total number of visitors (representing the special populations) at the hospital at a given time. That is, some visitors left the hospital before the questionnaires had been distributed. However, there is no reason to believe that the groups tested were unrepresentative in any gross sense.

On Family Day the visitors were mostly relatives and friends of patients at present in the hospital. During the lunch hour many took patients over to the picnic area and ate with them. Others visited on the wards where their relatives were. Most of the students were members of sociology or

TABLE 1

Attendance at the 1957 Mental Health Week program

	NUMBER ATTENDING	NUMBER IN SPECIAL POPULATION	NUMBER TESTED
Family Day	1,120	1,120	188
Students' Day	1,167	1,000	124
Clergymen's Day	134	72	38
County Officials' Day	209	209	100

TABLE 2

1. Have you ever attended the Mental Health Week program at this hospital before?

	YES	NO
Family Day	50	128
Students' Day	2	122
Clergymen's Day	16	22
County Officials' Day	37	62

social studies classes (seniors) from high schools in the area. There was also a sprinkling of students from small colleges and junior colleges. On Clergymen's Day half the visitors were clergymen; the remainder were wives, YMCA secretaries, etc. Those attending on County Officials' Day were probate judges, boarding home operators, county welfare workers, etc., who resided in the areas served by the hospital.

On all days the questionnaires were distributed as close to the end of the program as possible. They were filled out anonymously by the visitors who were seated in a large auditorium following some particular activity.

RESULTS

Table 2 reveals that except for Students' Day there was a considerable number of repeats among the visitors. This cautions against using the same displays or type of program on any consecutive years. A film, for example, which was quite popular this year would probably not be too effective next year unless a parallel program was scheduled. In this table and those to follow, there will be discrepancies between the tabular totals and the number of visitors as some respondents did not complete all items (because they did not realize that there were items on the reverse side of the questionnaire, etc.).

Table 3 shows that except for Students' Day only a very small number of visitors stated that they would not return next year. Most of the students were seniors who felt that since this was their last year in school this would also be their last attendance at a Students' Day program. The large number

TABLE 3

2. Do you plan to attend next year's Mental Health Week program at this hospital?

	YES	NO	PERHAPS
Family Day	67	10	99
Students' Day	14	53	55
Clergymen's Day	29	0	9
County Officials' Day	71	2	26

of "perhaps" responses for Family Day indicated in many cases that the person would return if the relative remained in the hospital. This shows that if the hospital authorities are concerned with increasing the community interest in the hospital it might be made clear to the families that they are welcome at the program regardless of whether or not their relative is in the hospital. The strong attachment to the hospital and its treatment program developed during the patient's stay could be made the basis of a sustained community interest in the hospital. When these results are taken in conjunction with those from Question 1 it appears that this is the first and last visit to the hospital for the student group (unless they become patients, friends or relatives of patients, or employees). Hence, particular care should be taken to provide for continuing constructive outlets for the interests of this group in the problems of mental health and illness.

As can be seen in Table 4, on almost all days the largest number of visitors came more than 100 miles to attend the program. This is not at all uncommon for state hospital populations. Some relatives drove as far as 250 miles to attend the program. This indicates the unfeasibility of scheduling activities in the early morning. Perhaps it is desirable to extend the programs later into the afternoon or evening rather than use the early morning hours.

Items 4 and 5 dealt with reasons for coming to the Mental Health Week program and were largely uninformative (i.e., relatives answered "to visit a relative," students answered "because my sociology class came," etc.). These items will be dropped from next year's questionnaire and a different approach will be tried in the attempt to assess the area of "motivation for coming."

Questions 6 and 7 dealt with the specific parts of the Mental Health Week program that the visitors thought the most and least interesting. They were the items of most concern to the various hospital committees. Several generalizations, such as the following, can be made from the responses:

- A documentary 8 mm. color film completely produced by the staff was generally very popular among all groups of visitors and felt to be more successful than any of the commercially produced films used in other years. This film follows a patient from admission, through the various types of treatment, staffing, etc., to discharge and return to her family. It was found that the film was a bit too long (running time slightly over an hour) for some of the groups (e.g., students) and a shorter edition (about 35 minutes) will be prepared to be

TABLE 4

3. About how many miles did you have to come to get here today?

	0–5	6–20	21–50	51–100	MORE THAN 100
Family Day	19	14	23	49	72
Students' Day	1	28	42	23	30
Clergymen's Day	2	4	6	16	10
County Officials' Day	3	1	16	31	44

used in place of the full version on appropriate occasions. Also, it will be duplicated on 16 mm. (with sound track) and future films will be made on 16 mm. rather than 8 mm.

- Whereas clergymen found active small discussion groups to be excellent they felt that far too much time was wasted in the mechanics of deciding who would be in which group and in the actual division into these groups. This could be corrected next year by having the grouping arranged in advance.
- Responses indicated that the panel for students was much too large (1,100 in the city auditorium); a majority couldn't hear a word of what was going on and there obviously was no possibility of general participation in the discussion. Next year this will be corrected by having Students' Day spread over several days (possibly 10) and having several concurrent smaller panel discussion groups each day. Attitudes towards these small group activities will then be evaluated.
- The students were quite antipathetic towards the tour of the grounds. There were many spontaneous comments that they saw little point in being conducted through the patients' dormitory, the hospital greenhouse or the new cafeteria. Those who liked the building tour indicated that they appreciated seeing the places where the patients lived and worked. These answers indicated that although the hospital staff may be justifiably proud of improvements in the physical plant of the hospital, the visitors may be far more interested in the treatment program. Perhaps Karl Menninger's stricture—"brains before bricks"—is becoming part of the public's attitude towards mental illness.

The results in Table 5 may be quite surprising to someone who has read of the public's need to participate, to join in discussions, especially where strong attitudes and motivations are involved. However, much of the literature in this area is based on work with highly articulate groups such as college students or community leaders. Kansas farmers and high school students may be far more interested in "being told" than in discussing topics about which they possess very little factual knowledge. For the clergymen and county officials there is a slight trend towards favoring participation in discussions rather than attending lectures. To illustrate even more graphically the influence of sub-culture norms on willingness to discuss issues, the results from a group of 30 student nurses were tabulated separately (rather than with the

TABLE 5

8. Do you prefer a program in which you yourself get to actively participate (such as discussions, asking questions, etc.) or do you prefer a program at which you attend more lectures and demonstrations?

	LECTURES AND DEMONSTRATIONS	PARTICIPATING IN DISCUSSION
Family Day	102	44
Students' Day	83	40
Clergymen's Day	16	22
County Officials' Day	43	46

TABLE 6

9. Before I came to this hospital I expected to find it most like:
10. Now that I am here I find that this hospital is really most like:

	FAMILY DAY		STUDENTS' DAY		CLERGYMEN'S DAY		COUNTY OFFICIALS' DAY	
	Before	*After*	*Before*	*After*	*Before*	*After*	*Before*	*After*
Like a school	12	25	10	41	3	8	5	8
Like a prison	34	3	19	3	2	0	9	0
Patients acting peculiar	52	1	59	5	5	0	14	1
Like a country club or summer resort	2	6	1	6	1	2	1	1
Like an army camp	4	3	0	1	1	0	0	0
Like a boarding house	8	17	6	19	1	2	3	10
Just like any hospital	62	104	23	36	20	20	49	52
What else	2	13	7	11	5	8	9	14

larger student group). Of these 30 student nurses, 22 preferred lectures to discussions.

Table 6 reveals the striking changes in perception of a mental hospital that can occur as a result of even a 1-day visit. Only one of the 450 visitors sampled indicated that he had a less favorable view of the hospital after his visit than before. The greatest reductions were in the view of "patients acting peculiar" and "like a prison." The greatest increases occurred with "just like any hospital" and to a lesser extent "like a school." Favorable descriptions increased from 207 to 357; unfavorable descriptions decreased from 199 to 17. (All of these changes are highly significant statistically). Almost all of the "what else" additions were laudatory remarks such as "a wonderful place for treating the mentally ill," "like a good mental hospital," etc. These results point up the value of bringing more of the community to visit the mental hospitals. It can be noted that this hospital certainly does not possess the most modern physical plant. Many of the buildings are over 30 years old. If attitudes can be altered to this extent by a visit to an older state hospital, the changes should be even more marked by visits to an ultra-modern hospital.

In Question 11 an attempt was made to solicit the suggestions of the visitors for improvements in the Mental Health Week program. This was an open-ended item and the number of responses varied from group to group. On Family Day there were further signs of the reticence of the respondents: only 10% of the sample mentioned any improvements. For the other groups, the figures were 58% (students), 71% (clergymen) and 36% (county officials). Most of the responses dealt with such matters as going through the wards, seeing more patient activities, arranging more discussion of treatment methods, etc. Several will be quite helpful to the staff in planning next year's program.

The answers in Table 7 indicate that the

TABLE 7

12. How did it make you feel to visit the hospital?

	PERCENT ON FAMILY DAY	PERCENT ON STUDENTS' DAY	PERCENT ON CLERGYMEN'S DAY	PERCENT ON COUNTY OFFICIALS' DAY
Curious	25	44	18	8
Depressed	8	7	3	3
Frightened	2	2	0	0
Sad	11	7	5	3
Nervous	6	4	3	0
Optimistic	6	6	24	16
Bored	0	6	0	0
Sympathetic	49	44	58	51
No feeling at all	1	4	5	2
Wanted to help	35	34	58	32
Guilty	4	2	0	0
Pleasantly surprised	33	17	26	24

students were the most "curious" and least "pleasantly surprised" of the groups, while the relatives were the most "pleasantly surprised." The only visitors who reported being "bored" were on Students' Day and the greatest number of "guilty" responses occurred on Relatives' Day. The predominant feelings expressed by all groups were "sympathy" and "wanted to help."

Table 8 summarizes the responses of those visitors who suggested actual improvements. It is important to note here that

TABLE 8

Type of improvements suggested by visitors *

	MORE BUILDINGS	MORE STAFF	IMPROVE QUALITY OF BUILDINGS	IMPROVE QUALITY OF STAFF	IMPROVE PHYSICAL CARE OF PATIENTS	MORE RECREATION FOR PATIENTS	MORE PUBLICITY FOR HOSPITAL OR MENTAL HEALTH	MORE OUTPATIENT SERVICE	OTHER	NO RESPONSE
Family Day	1	6	0	1	1	6	1	0	7	81
Students' Day	15	11	10	0	5	6	1	0	10	54
Clergymen's Day	3	6	6	0	0	0	24	6	6	63
County Officials' Day	16	13	1	1	0	0	4	7	4	67

* In percentage of total number of visitors.

on all days the majority of respondents either wrote something similar to "you're doing fine" or left the item blank. The percentages of visitors making concrete suggestions were 19 (Family Day), 46 (Students' Day), 37 (Clergymen's Day), and 33 (County Officials' Day). The figures in the table add up to more than 100% as many respondents made more than one suggestion. Although the proportion of visitors making comments is not large, the differences between the groups are quite interesting. The families made almost no suggestions about improving the physical plant of the hospital. It was the county officials and students who continually urged "more buildings," "make it larger," "more accomodations for more patients." For the county officials this is understandable in view of the pressures on them to have county residents admitted to the hospital. All groups recognized the need for a larger staff. It is encouraging to note that many of the visitors mentioned the need for more trained psychiatric aides, long the forgotten men of the treatment program. The clergymen were most concerned about obtaining more information on mental health and about the possibility of educative programs in their own communities. This becomes understandable when it is considered alongside the fact that every clergyman indicated that he had known personally someone who had been mentally ill. It has often been recognized that many families, upon suspecting mental illness in a child or relative, will call first upon their clergyman and only later upon their physician. Hence, there is a pressing need for greater mental health instruction for this group.

Several of the comments were quite perceptive and may prove to be of considerable practical value to the staff in effecting constructive changes. Here we may find such items as "relatives and friends should be allowed to attend the dances" and "have a list at the desk of patients who are able to leave with you for a visit so you don't have to wait so long for the doctor's permission." Others, such as the need for more personnel or more modern facilities, simply underscored what had been generally known.

The proportions in Table 9 are striking in that virtually all visitors felt that the Mental Health Week program had increased their interest in mental health. Informal talks with many of the visitors provided additional confirmation of this general feeling. How this interest can best be channeled constructively is a matter which warrants further investigation.

From the responses in Table 10 it appears that mental illness is becoming more widely recognized as a social problem. There is less denial of a friend or relative

TABLE 9

14. How has visiting here now affected your interest in the problem of mental health and mental illness?

	INCREASED	DECREASED	NO CHANGE
Family Day	134	4	7
Students' Day	105	1	14
Clergymen's Day	36	0	2
County Officials' Day	83	2	6

TABLE 10

15. Have you ever known personally anyone who was mentally ill?

	YES	NO
Family Day	131	10
Students' Day	76	40
Clergymen's Day	38	0
County Officials' Day	86	7

who is ill. Even in the comparatively young student group, two-thirds of the respondents report having personally known someone mentally ill. These figures suggest that there are important social implications in the oft-repeated figures on the number of persons spending some part of their lives in mental hospitals, i.e., in terms of how this impinges on other individuals and groups.

In planning this year's Mental Health Week observance it was often stressed that previous programs had provided few opportunities for contact between the visitors and the hospital staff, and that this contact should be greatly increased. The results of this effort are reflected in Table 11.

When the study was first proposed, there was considerable concern because of the belief that a high percentage of visitors would report that they couldn't find staff members or would find it difficult to talk to those they found. On the basis of the visitors' responses, these fears proved unfounded. The staff can derive considerable satisfaction from the impressions they made on all groups. The dominant impressions were of being easy to talk to, friendly, sympathetic

TABLE 11

16. What is your impression of the staff members at this hospital?

	PERCENT ON FAMILY DAY	PERCENT ON STUDENTS' DAY	PERCENT ON CLERGYMEN'S DAY	PERCENT ON COUNTY OFFICIALS' DAY
Couldn't find them	2	19	3	2
Easy to talk to	45	40	47	47
Distant	0	2	0	1
Sympathetic	22	12	24	25
Too busy to talk to me	2	2	3	2
Competent	27	11	60	57
Hard to talk to	3	0	5	2
Inadequate	1	2	0	0
Friendly	53	63	60	50
Unsympathetic	2	0	0	2

TABLE 12

17. Did you meet and talk to any staff members?

	YES	NO
Family Day	105	46
Students' Day	61	60
Clergymen's Day	33	4
County Officials' Day	73	21

and competent. The students were the least impressed of the groups but this can be attributed to the high percentage who reported that they did not have the opportunity to talk to any staff members. As indicated above, this will be adjusted next year by alloting several days for students (with special activities for seniors, college and nursing students, etc.), which will permit smaller group activities involving more student-staff contacts. The success of this type of grouping in relation to reported contacts is seen in connection with the clergymen.

The chief surprise in Table 12 was the high percentage of relatives who reported talking to a staff member. This still leaves one-third, however, who did not meet or talk to a staff member. Since Family Day occurred on Sunday, when the least number of professional personnel were at the hospital, and considering the positive responses of those who did contact staff members, it is planned to have virtually the entire hospital personnel present for Family Day next year. Unfortunately, we have little information as to whether the respondents were considering aides and administrative personnel as staff members. The study of what constitutes a "hospital staff member" for the various groups would be an interesting problem in itself.

Question 18 dealt with whether the staff members had answered the visitors' questions satisfactorily. Of those answering "yes" to Question 17, over 95% of each group answered this question affirmatively also.

Question 19 asked whether the respondent felt lost in the crowd. Only on Students' Day did any sizable proportion (50%) answer in the affirmative. Resolution of this difficulty has already been discussed.

TABLE 13

20. Do you feel that at some time you might be willing to do some volunteer work at this hospital?

	YES	NO
Family Day	78	39
Students' Day	62	47
Clergymen's Day	24	8
County Officials' Day	50	28

It is difficult to accept the responses to the item in Table 13 at face value. Some of the spontaneous comments, however, are most enlightening: "Yes, if possible, but due to distance it might be difficult." "I sure would like to but I haven't the nerve." "Would be proud if I were to be asked and would consider it a privilege." Even if only 10% of those giving affirmative answers were actually willing to do volunteer work, a considerable source of assistance for the hard-pressed hospital staff would be available, especially for the adjunctive therapies department (including recreation) where supplementary personnel are always welcome in the activities program, as well as in the other patient-oriented services.

These responses are also significant considered solely as expressed attitudes when contrasted with the representative attitude of many people (including adjacent townspeople) who have never visited the hospital, e.g., "I wouldn't go near that place for love nor money."

DISCUSSION

The writers had three objectives in doing this study. First, there was the matter of evaluating the Mental Health Week program, to which the staff members had devoted considerable time and effort. Most of the professional staff had belonged to one or more of the committees and were justifiably curious to know whether their efforts had been worth while. It was also felt that such an analysis would be of some general interest, as Mental Health Week programs are becoming more widespread in other institutions.

There was also the possibility of doing a study of attitude changes in a concrete, naturalistic setting. The second reason concerned the hopes that such a study might demonstrate to others of the hospital staff that research could be of considerable use to them in helping them evaluate their activities. In essence, to make explicit the generalization that research is a good thing. From this it might be possible to encourage other departments to join in and initiate research activities on other hospital problems.

The third goal concerned the matter of staff morale. It is a frequent argument against the prevailing policy of locating state hospitals away from any towns that one is unable to attract and hold an adequate staff because of the lack of cultural facilities. Hence, other inducements—such as housing on the grounds, free milk or free laundry for staff families—are often used. One means of attempting to remedy this situation is to institute a strong research program. If this can be done, the hospital staff may derive the support from such an activity necessary to compensate for the lack of cultural advantages in the community.

Considering these objectives in turn, the first question is whether the effort expended in the Mental Health Week program was warranted by the results obtained. At first glance the figure of more than 1,000 man-hours devoted by the professional staff to the preparation of the program seems unreasonably high, especially when the services of the professional staff are in such great demand. However, it must be weighed against the accomplishment of the program. If we can assume that our sample of the visitors was representative, and there seems little reason to doubt this, then we may infer that over 90% of the visitors increased their interest in the problems of mental illness. Hence, for every man-hour that the staff spent in preparing and carrying out the program, the attitudes of approximately two visitors were favorably influenced. In addition, although we cannot measure directly the ultimate effects of the change in

the perception of the hospital from "like a prison" to "just like any hospital," we may hope that they may someday manifest themselves either in the readier acceptance of former patients in the community, or more prompt recourse to the local mental health facilities in times of need. Individuals who believe that mental hospitals resemble jails are not likely to commit their relatives if there is any chance to keep them at home. Many times incipient conditions are allowed to become more serious because the patient's family is unwilling to send him to a state hospital. It is not too much to hope that the changes in attitude indicated by the questionnaire may result in more enlightened practices by some of these visitors in the future. It is important to realize that some additional effort may be required by mental health personnel before this interest can be channeled constructively. Even the most enlightened citizenry may require some professional assistance in forming a local mental health association. Visits to state facilities can and do arouse interest, but it requires further planning to bring about organizations that can maintain that interest over a period of time.

The same situation obtains when the question of volunteer workers is considered. The questionnaire responses revealed a considerable pool of potential volunteers that were not being utilized at all. Some hospital personnel had previously urged that a full-time director of volunteer services be employed but no authorization for this had been forthcoming. The present results demonstrate that with a modicum of additional effort perhaps a score of townspeople can be induced to come to the hospital on a weekly basis. Even if a full-time coordinator of volunteer services could not be hired, a place can be set where visitors to next year's program could register if they were willing to do some volunteer work. When such community interest exists, it can be utilized to supplement the hard-pressed hospital resources, especially the patients' recreational activities.

In considering the unique group of visitors that came on each of the four days one should not lose sight of the indirect effects of the Mental Health Week program which, although secondary to the direct effects already discussed, were equally pertinent to the over-all evaluation. In particular, one must consider how the effects of the Mental Health Week program for these four selected groups of visitors can influence non-visitors. The clergymen might serve as an example. If we look at their characteristic responses to items 12, 14, 15, 20 and 13 we find that they felt sympathetic and wanted to help, that their interest in mental health had been increased by this experience, that mental illness was a problem with which all of them had direct contact, and that three-fourths of them expressed willingness to do volunteer work in this area. In suggesting improvements, they indicated the need for increasing publicity for the hospital or mental health four times more frequently than any other suggestion. In view of this pattern of responses we realize how effective they can become in furthering such educative publicity: a conservative estimate of the number of parishioners directly represented by 100 of these clergymen is 25,000. Similarly, the potential influence on wider groups by the county officials, students and relatives can be inferred.

In terms of the first objective of the study, the questionnaire responses:

- Demonstrated to those concerned that their efforts in preparing the program were largely successful.

- Showed the strong and weak points of the Mental Health Week program so that

specific changes can be made in planning next year's observance.

- Brought forth the specific need of the community regarding mental health facilities that might be met to some extent by the hospital personnel.

- Revealed untapped sources of volunteer workers that could be utilized to supplement and enlarge the hospital's treatment program.

Regarding the second objective of the study, to demonstrate the value of research activity to the hospital staff, the effects of the study can be considered only as tentative at this point. It seemed preferable to await concrete signs of such interest rather than to distribute an "attitude towards research" scale among the hospital staff. However, each of the individuals concerned in Mental Health Week was extremely interested in knowing the visitors' response to the program on the days for which he had responsibilities, as well as to the over-all program. All agreed that certain changes should be made in next year's program in the light of the questionnaire findings, and a committee was appointed to study the results in detail.

Although no one explicitly stated that research in general should be encouraged within the hospital, there were some heartening developments following the study. Several members of other departments approached members of the psychology department and asked their assistance in designing studies to meet their own particular research problems. This was not done on an inter-departmental level, but rather on the level of one professional worker asking another to contribute his skills in solving particular problems. This happened on three separate occasions within a week after the preliminary results of the study had been disseminated. It is too early to know whether these projects will materialize but the latent interest has been brought to the surface. Also, the hospital's interest (which in past years had been rather conspicuous by its absence) was expressed. The four key psychiatric administrative supervisors enthusiastically stated that this was just the type of "practical" research that should be encouraged in state hospitals. This expression of their willingness to sponsor such "practical" research could lead to the development of an appreciation of the practicability of undertaking more "theoretical" investigations. This is an encouraging sign for a geographically isolated state hospital that has been almost exclusively service-oriented, if not custodially oriented, for over 40 years.

It is even more difficult to assess the effects of the study on the morale of the professional staff. No one who had been a part of the study could help but notice the sense of purpose of the participants; this was "our hospital's study." One concrete result is that the weekly departmental seminars are currently becoming more regularly involved with the discussion and implementation of research proposals. One previous project is being brought to completion and extensions of this, and new, projects are being discussed. In addition, staff members are now more alert to problems in the hospital that could be studied.

It was agreed by the Mental Health Week Committee that in the future an evaluation should be done of each year's program. Results will influence the planning of these activities, and the method of evaluation will itself be refined with a view to constructing an instrument optimally suited to the assessment of the structure and effectiveness of Mental Health Week programs. It was suggested that next year we also investigate the

effect on patients of this influx of thousands of visitors; how do the patients perceive the phenomena of the Mental Health Week program and what are their attitudes and suggestions?

SUMMARY

As the annual observances of Mental Health Week constitutes one of the few links between state hospitals and the surrounding communities, and considerable time and effort are invested in them, it is important for hospital authorities to gauge their effectiveness. The present study represents an evaluation of a 4-day program at a midwestern state hospital which was attended by over 2,500 visitors.

A 20-item questionnaire was administered to randomly selected groups each day. The visitors completed the forms anonymously. Some of the more important findings of the study follow:

1. On some days, more than half of the visitors had attended previous Mental Health Week programs at the hospital. Hence, it seems inadvisable to use identical activities or displays on succeeding years unless parallel activities are scheduled.

2. Although most visitors are interested in returning to next year's program, a large number are not sure. This may indicate the value of informing the relatives that they need not have a family member in the hospital to attend a Mental Health Week program, and of considering ways in which graduating high school seniors may continue to find constructive outlets for their interest in mental health issues.

3. The largest number of visitors drove over 100 miles to attend the program. This showed the need for scheduling activities in the afternoon and evening rather than in the morning.

4. Many visitors resent a "guided tour" approach to the Mental Health Week program. They prefer to see the treatment facilities and patient activities rather than the physical plant of the hospital.

5. There were marked differences between the groups as to the types of program they preferred. Families of patients and high school students preferred hearing lectures to participating in discussions. More articulate visitors, such as clergymen and county officials, were evenly divided as to which they preferred. These differences in preference raised the question of optimal use and structuring of "participation" activities.

6. There were striking changes in the visitors' perception of the hospital. Many who expected to find it "like a prison" and with "patients acting peculiar" reported that they found it to be "just like any hospital." As a result of the program, favorable descriptions of the hospital increased from 207 to 357; unfavorable descriptions decreased from 199 to 17.

7. The most frequently aroused feelings of the visitors were sympathy and a desire to help. This raised the question of possible modes of involvement.

8. In suggesting improvements for the hospital, the patient's relatives focused on securing more staff and increasing the number of recreational activities for patients. The students were more interested in improving the buildings and more staff. The clergymen were most concerned with more educational programs for mental health. The county officials were most interested in enlarging the hospital and in more outpatient services.

9. Visitors generally had very favorable impressions of the hospital staff members they

contacted, considering them friendly, easy to talk to, sympathetic and competent.

10. Over 95% of the visitors on all days reported that the program increased their interest in mental health.

11. A high percentage of the visitors reported that they would be willing to do volunteer work at the hospital.

The results of the study were well received by the hospital staff. Certain specific changes in next year's program were recommended. A more favorable climate for research activity was created, and several staff members from other departments expressed an interest in undertaking studies relating to other aspects of the hospital's psychiatric program.

LUCILLE HOLLANDER BLUM, PH.D.

Not all are definitely defective

Some observations on pseudo-retardation and parental concerns

The instances of conspicuous difference between a child's level of functioning and the level of his capacity are almost legion. In my experience it is far from uncommon for parents to bring their child to my office with the complaint that he is doing poor or failing school work. The results of individual intelligence tests then frequently show the child to have mental abilities which more than qualify him to deal with what is required of him at the time insofar as school achievement is concerned. An impressive example of what can exist by way of disparity between levels of performance and potential is the case of a 12-year-old youngster who was referred to me because of failing grades. Tests showed he had an intelligence quotient of 161, which classified him not only as having very superior capacities but also placed him in a group equaled or excelled by only one out of 10,000.

Along with their concern about the child's achievement parents frequently voice complaints against the school, the teacher or both. And while there may be real reasons for criticism of the school, findings indicate that the difficulty occurs at least as often among children who attend a school of high standing as among those who do not. In fact, inadequacy of functioning by the child seems to have its roots not so much in the school as in the almost universally chronic disorder among parents, namely, the endless worry to help the child get quickly ahead!

The factors in our society of strong environmental pressures and competition to achieve have been pointed up by research workers in the field. Child (6), for example, in a discussion of cultural pressures and achievement motivation states: "The degree of stress upon achievement in our child training is very high indeed, strikingly illus-

trated by the fact that achievement pressures are in a sense exerted even at an age when they cannot possibly have an effect, as in praising a young baby for his birthweight or his liveliness, or at an age when they can hardly be other than detrimental, as in the early imposition of severe demands for achieving cleanliness."

With pressures for early motor and verbal development as forerunners, intellectual accomplishment becomes the focal point of parental concern, and consequently for parental demands, as the child nears school age.

In defense of the parent, it might be said that his own feeling of uncertainty as to his role and his child's future seems an important factor in the strenuous demands he makes.

Obviously enough, every child does not respond with inadequate behavior to the standards set up for him. The particular child's response depends upon a whole set of more or less complex circumstances which include such factors as the overall parental attitude, the degree of pressure and the child's intellectual equipment. A very superior child may, for example, tend to take on the high goals that his parents have set for him as his own goals and so function very competently at a high level.

DEVELOPMENTAL READINESS AND ENVIRONMENTAL STIMULATION

On the other hand, fundamental principles of growth and development play an all-important role. These laws indicate the influence of maturational factors on the child's ability to profit from "nurture," whether in such matters as training for bladder control and walking, or in intellectual performance.

The principles of growth and development as they relate to rehabilitation of the cerebral palsied child and to problems of retardation in general have been considered in earlier studies (2, 3). In these papers the effects of special stimulation are discussed. It will be sufficient to report here that research reports dealing with acceleration of mental growth through added stimulation or pressure describe results which on the whole tend to be negative. The exceptions are those instances where there has been marked deprivation.

Negligible results where special methods to hasten development have been brought to bear seem to hold in such fields as nutrition and clinical endocrinology (4) as well as in educational programs.

In a study designed to determine whether or not specialized training raises the child's intelligence quotient, Graves (7) found notable increases in IQ's of children who were tested, coached and retested with the same items. A falling-off of increment with the passing of time was found, however, in the tests three months and one year later. Grave's study illustrates how a child sheds or sloughs off, so to speak, what he is developmentally unready to assimilate.

An aspect of the expression of growth indicated by the foregoing study is the principle of resistance to displacement. Olson (11) describes the principle as follows: "Any organism in a systematic rate of change of growth tends to resist displacement caused by factors involving extra stimulation or deprivation and to restore a projection of the original rate when the factors are removed." It might be added that restoration of the original rate refers to the course of development particularly characteristic of the given child.

Developmental laws are well summarized by Olson. He states that the child has a design for growing. Optimum nurture fulfills the design. A child tends to grow more rapidly to make up for temporary periods

of deprivation. But attempts to force growth are resisted.

EFFECTS OF PARENTAL PRESSURE TO ACHIEVE

Dynamically, a child normally seeks nurture in activities in accordance with his growth potential. From the standpoint of the environment, the child tends to respond with the behavior esteemed by his culture—if the behavior is within his present equipment for possible successful response. Success brings with it the most gratifying reward, love from parents or other significant figures. On the other hand, behavior that is not adapted to the expectancy carries the likelihood of parental disapproval and threat to security.

Again it should be stated that there is no simple cause-and-effect relationship in instances where the child's functioning is inadequate to his capacity. The multiplicity of factors which may be associated with the problem is suggested by Pearson's (12) survey of learning difficulties. Pearson points up that learning difficulties are essentially a problem of ego psychology. The various factors which hinder the ego may occur in the ego itself or as the result of influences emanating from superego or id. He considers eight different groups of causes of diminished capacity to learn with both direct and indirect influences.

For purposes of this discussion, however, it seems sufficient to state that consistent with what is known about the nature of development and adjustive behavior, marked differences between levels of capacity and functioning are usually symptomatic of the child's failure in dealing with harsh demands.

In addition to poor scholastic achievement there are frequently other symptoms as products of the difficulty in the child's capacity to adapt to environmental pressures. These symptoms appear initially in the psychological testing situation as apprehension, timidity and uncertainty, and in a readiness to give up rather than attempt to work through a test item which would normally be a comfortable challenge. In most instances, however, these children tend to respond favorably to an individualized approach to obtaining an estimate of their mental abilities. I have found that in an atmosphere which appears casual and pervaded with reassurance and encouragement the quality of the child's total performance usually approximates that of his potential or capacity.

It is indeed regrettable that the stern measures which seem to cause the psychologic disfunctioning in the first place become even more severe as the child demonstrates his inability to achieve. What seems to occur is that parental concern becomes intensified and thus the child's symptoms are exacerbated.

THE PSEUDO-RETARDED CHILD

There is another group, however, with psychologic disfunctioning where the implications are far more serious. I refer to those children who have normal or superior potential, fail in school work and, in contrast to the former group, show defective mental capacity on the basis of intelligence test performance. It is with this group, the so-called pseudo-retarded, that this discussion is primarily concerned.

A diagnosis of pseudo-retardation is a diagnosis in retrospect: a child previously diagnosed as retarded subsequently is found not to be. Obviously, the extreme gravity of the problem rests in the earlier diagnosis. The management of a child who is irreversibly feebleminded differs considerably from the care and handling of a child whose potential is average or better.

The literature on pseudo-retardation suggests that the diagnosis is generally psychometrically oriented. I have found that the psychometric results—with its classification "retarded,"—in most instances merely tends to supply objective evidence of what the adults who are in daily contact with the child already believe. In other words, the child's behavior has already, in one way or another, raised doubts about the normalcy of his mental status.

It is not to be presumed that an incorrect diagnosis implies a careless or necessarily inexperienced approach. Cassel (5) points out that the most experienced and painstaking clinician may be guilty of insufficient examination. Cassel states that although every one of the specific causes appears to be quite obvious when singled out, in the clinical situation they often remain obscure. Kanner (8) lists a number of conditions which are especially apt to mask the child's intellectual potential. Among these conditions are visual difficulties, hearing impairment, negativism and schizophrenic withdrawal. In his discussion of feeblemindedness Kanner describes the "determinants" necessary to be considered in every instance of retardation. The many aspects of the problem of understanding the condition are perhaps best indicated by his list of determinants. These are: genetic, cultural, material, physical, educational and emotional in kind. Similarly to Kanner, others in the field have given rather comprehensive lists of conditions or groups of individuals in discussing pseudo-retardation.

In contrast, the present consideration of casual factors may perhaps seem somewhat of an over-simplification. If inadequate functioning such as that described earlier may be regarded as indicative of the child's failure to adapt to environmental pressures, then I believe it may be said that pseudo-retardation is evidence of the child's further inability to respond to severe demands. Contrary to the group whose functioning is inadequate, but whose levels of test performance and capacity are comparable, the pseudo-retarded child not only functions inadequately but has developed a wall of stupidity to defend himself from external stimuli which are anxiety-provoking and with which he is unable to cope.

Other writers have described pseudo-retardation from a somewhat similar point of view. Altable (1), for example, says that the pseudo-mentally deficient individual is one with disorders of personality which cause a diminution of his cognitive capacity. An all-important question might then be raised as to the nature of the environmental demands which cause these children to adjust in the particular way they do.

It would seem that where pseudo-retardation occurs the child has protected himself from pressures even more formidable than the very strong achievement strivings which, as indicated earlier, characterize our society. On the other hand, the unreasonably high demands which the parent imposes in these instances appear to be an expression of his own deep concern, of which he may be unaware, that perhaps his child hasn't the intellectual equipment to make the grade, so to speak, at all. But what are the threatening elements which cause these parents to be beset with such fears and misgivings?

Some answer to the question appears to have emerged from the data that I have obtained in my history-taking of children brought to me for examination because they were presumably retarded. I have noted almost invariably that the child was an adopted child or he belonged to a family where there already was a member who suffered a mental disorder either organic or functional.

PSEUDO-RETARDATION AND ADOPTION

It is readily recognized that adoption is for the adopting parent an experience with deep emotional aspects. The strong personal significance of adoption is suggested by McCormick (10), who points up that the ability to produce a child is a fulfillment of womanhood and manhood, a sort of proof of adequacy against the insecurities and anxieties present in every human personality. It has been suggested that adoption is basically an attempt to compensate for the failure to procreate.

In line with the attempt to compensate for what they regard as an inadequacy, the adoptive parents frequently seek to obtain "a perfect child." This is often reflected not only in the exaggerated concern over inconsequential defects when the adoptive parents first see the child, but also later in the high goals set for him. In such instances the very harsh conditions under which the adopted child may experience acceptance make his poistion, from the standpoint of security, a most tenuous one indeed. The parental attitude, readily felt by the child, appears to be suggested by Prentice (13) in her book, *An Adopted Child Looks at Adoption,* when she says, "The burden of my obligation to be a perfect specimen was too much for me."

Coupled with the doubts about themselves, adoptive parents frequently worry lest the child evidence some undesirable traits of his own, since in most instances the identity of the child's true parents is withheld. It can be seen then how anxiety about unknown factors, together with the adoptive parents' feeling of inadequacy relating to their role, might cause them to exert pressures on the child even more strenuous than those exerted by natural parents.

It should perhaps be indicated here that the foregoing interpretation does not intend to imply that an atmosphere of anxiety and unreasonably high standards insofar as the child's achievement is concerned are representative of adoptions in general. If the ability to function adequately is used as a measure of adjustment, then it may be said that in many instances of adoption the reverse condition prevails, *i.e.,* the child enjoys the kind of acceptance which encourages the release of abilities. That there are in many instances conspicuous developmental gains subsequent to the child's placement with adoptive parents has been confirmed by Dr. De Leo, attending pediatrician at the New York Foundling Hospital. In a recent conversation with him he told me that through the years he has frequently noted impressive progress when children he had examined developmentally prior to adoption visited the hospital at school age. My data, however, suggest that pseudo-retardation in an adopted child is an outcome of severe pressure by the parent for the child to achieve.

The following two cases are presented as illustrative of the problem.

MARY S, 11 YEARS, 9 MONTHS

Mrs. S's chief complaint about Mary was that she was doing very poor work in school and showed lack of interest. Mary had been adopted at the age of 1½ years. The information that she was an adopted child had been withheld from her. She was the only child in the family. Subsequent to the adoption, the family had moved several times in a few years, which Mrs. S believed was the basis for Mary's "unsettled feeling."

Mrs. S appeared to be in her early forties. Her manner in general, especially her speech, seemed somewhat hurried. She had worked intermittently during Mary's early

years, and Mary was cared for by her grandmother. At present Mrs. S was employed as secretary in an educational institution. Mr. S was in government employ in a supervisory position.

Mrs. S told me that Mary had been tested prior to adoption and that the results indicated she was "college material." But the child's school history seemed to bear evidence to the contrary. Mary had been left back twice in the second and third grades and at present was failing miserably in all subjects in the fifth grade, where she had been placed so that she could be with children her own age. Living in a suburban community, Mrs. S feared Mary would be singled out as the "town idiot."

Through the child's early years the adoptive parents approached the problem in a "very stern and impatient" manner. This information Mrs. S volunteered. She added that both she and her husband had subsequent feelings of guilt. They were now earnestly attempting to be patient and understanding. The parents' intense anxiety toward their young adopted daughter seemed further reflected in the very strong punitive measures resorted to in their effort to get her to achieve according to their expectations. For example, in the supervision of school homework, the mother would stand over Mary with a paddle in hand which she applied whenever the child gave an incorrect response.

PSYCHOLOGICAL EXAMINATION

Mary was a sturdy-looking youngster who seemed somewhat heavier than average for her age. She was impeccably dressed in a starched blue cotton dress. Her manner was friendly and she smiled as she responded to my comments made in an effort to engage her in informal conversation.

She responded to the intelligence test items with seeming apprehension and uncertainty. Her answers were slow and labored and she showed a tendency to give up readily and say, "I don't know." She frequently injected self-critical comments relating to her responses such as, "I made it crooked" and "I wish I could get it right." In the item, number concepts, she placed the blocks with meticulous care; her figure drawings were characterized by rigidity of line.

On the Revised Stanford-Binet Scale of intelligence, Mary obtained a mental age of 6 years, 4 months and an intelligence quotient of 54. This of course placed her in the classification "mentally defective." She passed the vocabulary test at the 6-year level. Her highest success was at the 8-year level in a test involving memory of a story.

Mary's response to the Rorschach test showed, on the other hand, that the youngster definitely and unquestionably had superior capacities. It might be mentioned here that my estimate of Mary's capacities was confirmed by another worker who, independently and without any information other than the necessary facts such as age of the subject, analyzed the total Rorschach record. This procedure of so-called "blind analysis" was also carried out with on the other two Rorschach records discussed below.

In Mary's case, there were features[1] in the responses which are not found in instances of true feeblemindedness. The record showed that she was unable to function on a level comparable to her capacities because of severe emotional interference which at times was so marked that thinking became irrational. The content of the record showed in fact that extreme environ-

[1] The responses indicated good form; there were more than the average number for her age, both of whole responses, which were well organized, and movement responses.

mental pressure had been exerted for Mary to achieve intellectually and that she had been overwhelmed by this treatment.

In the social area, almost complete repression of spontaneity was indicated. She tended to avoid social contacts whenever possible even though the record showed clearly that basically she was outgoing. Her avoidance of contacts pointed in the direction of an environmental problem with which she was unable to cope.

A final aspect of the Rorschach protocol that is pertinent to this discussion is that it contained many neurotic features and indicated urgent need for psychiatric help. The record resembled most closely the records of poorly adjusted anxious psycho-neurotics with schizoid trends. On the basis of the total picture, one would expect that if a break did occur it would be in the direction of a psychosis.

The conspicuous difference between Mary's level of performance on the one test and level of potential as indicated by the other points up further the importance of basing evaluations on more than one diagnostic technique. Particularly where there has been strong parental pressure for intellectual achievement, the child frequently is threatened when confronted with questions such as those which make up intelligence tests and are asked in accordance with standardized techniques. The testing situation has for the child too many elements which bear similarity to painful home experiences and parental testing of his achievement. The Rorschach technique, with its unstructured material and opportunity for freedom of response, seems in most instances to be less anxiety-provoking.

Again there are times, however, when an estimate of intellectual status based to some extent on objective measurement has, of necessity, to be exclusively psychometrically oriented. This was the case in examining Alice.

ALICE, 3 YEARS, 3 MONTHS

There was an urgency to Mrs. C's request for an appointment. The reason she gave was that only a few days remained before the expiration of the 1-year period to legal adoption of the child. Mrs. C said Alice's problem was poor comprehension as well as limited speech. She further reported that Alice cried and rocked in bed at night —all signs, as Mrs. C put it, of retardation. There had been a recent examination by a professional worker which confirmed the adoptive parents' suspicion of feeblemindedness. Mrs. C said she wanted another opinion since there was still time to "give the child back."

Both parents accompanied Alice for the examination. Mrs. C appeared to be in her late thirties. She was a former elementary school teacher. Her upset was quite apparent by her manner in general and by the tears which readily came as she spoke about Alice. Mr. C seemed to be in his early forties. He was self-employed in manufacturing. He had a quiet manner and his only participation in the conference was to inject a comment here and there, as Mrs. C excitedly poured out the complaints and gave the information in response to my questions. The adoptive parents had a child of their own, a boy of 7.

PSYCHOLOGICAL EXAMINATION

Alice was a nice-looking little girl of average size for her age. She sat quietly with seeming interest in the test materials as I presented them. There was no understandable speech during the period of examination. At the outset she appeared to have considerable difficulty in comprehending

the test questions and directions in response to the Revised Stanford-Binet Scale. I soon found that once Alice did understand what she was requested to do she gave a direct response quite unlike that of a true feebleminded child. She achieved success on the 3-hole form board at the 2 years, 6 months level and at the 3-year level, and at the 3-year level she also passed the following tests: stringing beads, building a bridge, and copying a circle. Drawing a cross was successfully performed at the 3 years, 6 months level. The Stanford-Binet Scale is heavily weighted with verbal items, and speech seemed the stumbling block in Alice's case. Consequently I could not obtain a mental age and IQ on this test.

By now it occurred to me that a hearing impairment might possibly be a causal factor in the seeming retardation. And so I attempted to get some objective evaluation of Alice's abilities by introducing the Merrill Palmer scale, an intelligence test made up largely of items requiring the manipulation of concrete materials. When necessary, I used gestures to communicate directions.

Alice's response to this test was in marked contrast to her earlier behavior. She worked steadily along, smiled and seemed pleased with her accomplishments. In a couple of instances she even sang as she worked. Her highest success was with two tests (picture puzzle and form board) at the 54–59 month level. On the basis of her performance on this scale her mental age was 3 years, and 4 months; her IQ 103. This estimate of Alice's intelligence I regarded as minimal and influenced by what I now felt to be the handicap of defective hearing. (That Alice had impaired hearing was confirmed some days later through hearing tests.)

Since the measure of Alice's intelligence placed her within the normal range she did not, of course, come under the category of pseudo-retarded as described above. I have included this case, however, to point up how essential it is in the clinical situation to consider all possible determinants of apparent retardation. But I have also cited this case to indicate that even where there is some defect, such as Alice's defective hearing, it is frequently the parent's attitude, more than the defect, which contributes to the retarded behavior. For Mr. and Mrs. C their adopted child's delayed speech and difficulty in understanding what was said readily became evidence substantiating the doubts and misgivings they had to begin with. The intensity of this adoptive mother's anxiety about the intellectual status of her child was conspicuously reflected in her response when I gave the report of my findings. She cried, questioned the test results, and held to her conviction that Alice was feebleminded.

INTELLECTUAL IMPAIRMENT IN THE FAMILY

The histories of the rest of the group under discussion showed that in almost every instance there was a family member—a sibling, paternal or maternal uncle or aunt—who had preceded the pseudo-retarded child with disturbance in intellectual functioning. Although there was this familial coincidence (and inheritance cannot be ignored), my data tend to show that it was not heredity but the parent's idea of heredity that figured in the pseudo-retardation. Regardless of the causal factors, these parents felt that the deviant behavior already present in the family predestined the child to comparable mental disorder. This notion was enough to add weight to the anxiety that the parents had already experienced in their relationship to their child.

The way in which parental anxiety can override reason and logical thinking is evidenced in the case of Joan.

JOAN F, 6 YEARS, 11 MONTHS

Mrs. F brought Joan to me on the advice of her pediatrician. The mother's complaints were that her daughter was sluggish, mentally slow and unwilling to learn. Joan was in the second grade but doing very poor work, and she couldn't read.

A note to me from the referring pediatrician stated that Joan seemed to suffer some retardation. The doctor reported that examination showed nothing pathological. Tests for hypothyroidism were negative.

PSYCHOLOGICAL EXAMINATION

Joan was taller and heavier than average for her age. She wore glasses. She was slow-moving as she walked to the room for the testing, and this seemed her characteristic gait. Once seated, she was friendly and talkative.

During the testing she would become distracted for a brief period and then return to concentrated attention. Throughout, she made frequent comments on her intellectual functioning such as "I'm smart," "I even know how to color and read, but I can't write." She responded to praise of her performance with the comment, "That's being very smart. My mother will know that I'm perfect."

On the Revised Stanford-Binet Scale Joan obtained a mental age of 5 years, 4 months. Her intelligence quotient was 77. The test results classified her as "borderline defective." There was a wide scatter and unevenness in her performance. She failed as low as the 4-year level, passed items at the 8-year level.

Joan's response to the Rorschach test showed that she had superior intelligence. It showed her to be very productive with good imagination. Anxiety and basic insecurity were indicated. The record showed, in fact, that one would expect some difficulty in behavior because of her insecurity and need to work out some method of defense.

The severe demands made upon Joan by her mother became apparent in my interview. For example, she had made a persistent attempt to change the child's handedness from left to right. At the time, she was making strenuous efforts to get Joan to read. There was also worry because Joan couldn't write on a straight line. Mrs. F said this against progressive education: "They don't believe in forcing. If she doesn't want to learn, she doesn't have to."

Mrs. F volunteered that she herself had been an honor student. She felt, however, that her intelligence was "just average." Her husband, a government official, had superior intelligence, she believed.

She seemed deeply moved when, in reporting the results of my examination, I told her that her daughter had superior potential. It was at this point that she let the skeleton out of the family closet. She told me that she had a son, now 11, who had suffered a brain injury in a difficult birth with instruments, and as a result he was defective. She had been told that mentally he would not mature beyond 7 years. She quietly admitted that she had always been very worried about Joan because of her brother. And then this mother who only a few minutes earlier had told me of her own outstanding academic success asked, "Is it hereditary?"

Authorities in the field of personality disorders have in most instances included intellectual impairment in their character-

izations of the child with schizoid or schizophrenic personality. A good deal of inquiry into the etiology of these disorders has been carried out, but as Kanner (9) indicates much of the research has been limited to endogenous factors and little attempt has been made to bring parental attitudes and childhood schizophrenia into relation to each other.

In his *Child Psychiatry* Kanner concludes his consideration of the nature-nurture controversy with this observation: "Persons are accessible and modifiable, genes are not. A child, his attitudes, and other people's attitudes toward him can be reached and 'adjusted.' "

The progress in the following case gives credence to Kanner's principle and at the same time shows again how the factor of already present impaired intellectual behavior in a family member can tend to influence the mother's attitude toward her child.

PETER G, 5 YEARS, 1 MONTH

My contacts with Mrs. G and Peter were at a child therapy clinic.[1] The mother brought the child upon the advice of his pediatrician. Mrs. G wanted treatment only for Peter but finally agreed to go along with the clinic's policy that she also be seen on a regular basis.

Mother and child had separate sessions once a week for two and a half years. Their visits were interrupted shortly after treatment started because Mr. G became ill. Treatment was resumed after an interval of a year and a half.

Mr. G's complaints in the initial interview were that Peter was a stubborn child and that he seemed backward and didn't seem to understand what was said to him.

Mrs. G was 42 years old. She was careless in appearance and there was a somewhat stark aspect to her dress; she didn't allow herself the adornments of which, she later confided, she was so fond. Her manner was brusque. She sat poised, especially during the early phases of therapy, as if to defend herself and at the same time with what appeared to be an air of readiness to take off and get back to her daily chores. In addition to the management of her household, she relieved her husband every afternoon in the small neighborhood stationery store they owned.

Peter's father was 50 years old. He was of large physique and immobile expression, and spoke and moved slowly. He worked hard in his store, but in contrast to his very efficient wife he seemed to accomplish results far from commensurate with the effort invested. He lived a very circumscribed life in which work and rest figured largely. When his wife was in the store he would take over the care of Peter. He disciplined a good deal with threats and physical punishment and was greatly feared by Peter. There was one other child, a boy of 16. The several contacts that I had with Mr. G indicated he had a schizoid personality, and his history suggested that in the past there may have been several psychotic episodes.

It is not within the scope of this paper to consider the dynamics of the case nor to describe in any detail Peter's and Mrs. G's progress in therapy. In line with the present discussion it should be pointed up that Peter's brother was also experiencing difficulties in adjustment, but they did not affect his intellectual functioning. In fact, he was an honor student. One symptom of Peter's difficulties was his apparent retardation. Mrs. G had been exceedingly over-protective with both her children, and she had dominated both. There appeared

[1] The Postgraduate Center for Psychotherapy in New York City.

one conspicuous difference in her attitude toward her two children. Her older boy had been a quiet child and complied readily. His compliance reassured his mother. Peter, on the other hand, had been quite active. When he learned to move about, his mother said, he became destructive. Mrs. G told me how shocked she had been one day when Peter pulled two tubes out of the radio set and broke them. His behavior confirmed Mrs. G's greatest fear, namely, that her child had inherited the personality disturbance of his paternal uncle. Mr. G had a brother 32 years old who, the family doctor informed me, was schizophrenic and had undergone hospitalization several times. Mrs. G could not forgive her husband that this illness in the family had been withheld from her prior to their marriage.

The idea that her child was defective increasingly obsessed this mother. With her anxiety thus intensified she took Peter from doctor to doctor for an opinion. In one instance, glutamic acid had been prescribed. Mrs. G would ply Peter with questions to test him and to determine whether he could give reasonable answers. She told me that her brother-in-law did not understand too well what was said to him. Even before Peter entered kindergarten, his mother tried to teach him to read and write. She was afraid that he would be placed in a class for the retarded.

PSYCHOLOGICAL EXAMINATION

The following is from a report of tests given to Peter when he was 4 years, 9 months. The report was sent to the clinic by the psychologist who examined him at that time.

Peter looked more like a 6-year-old than his 4 years, 9 months. He talked in a slow, laborious monotone as if each word had equal value. Frequently his spontaneous talk rambled in a disconnected way from one subject to another. He followed suggestions and directions, but in a slow way and after a noticeable lapse of time. He showed little spontaneous interest in play, only a desire for physical activity and exploration.

On the Stanford-Binet test Peter achieved a mental age of 3 years, 7 months. The intelligence quotient was 75, which classified him as "borderline defective."

The Rorschach record showed a tendency toward uncontrolled excitability when he was emotionally stimulated. There was neither the ability to adapt to others nor an attempt to make others adapt to him. There was just an excitability. The record further showed a tendency when he was left on his own to cling to, or to revert to, old infantile patterns of behavior. A good deal of free-floating anxiety was aroused on those occasions when he sought to lean on someone.

The psychologist concluded the report with the statement that the weight of the test results and of the behavioral observations strongly suggested a schizoid process as the main problem.

For some time Peter's behavior in therapy was very much like that described in the Rorschach report. To a large extent he behaved as if I were not present, and he tended to become highly excitable as he played with the toys in a repetitious and destructive way. When he did turn to me, which was infrequently, it was to request a story; it always had to be the same story read in exactly the same way. As he progressed, he began to relate by reporting what occurred in school (as he customarily did in response to his mother's questions) and by turning the pages of his notebook again and again to show me his school work. It was with much difficulty that he gradually

was able to forego the ritual pertaining to school work and to play with me.

In a retest when Peter was 7 years, 6 months old his mental age was 7 years, 9 months and his intelligence quotient 103. On the basis of the test results Peter was classified as "normal or average." Test results were considered minimal at that time.

That Peter's potential was higher than that indicated by his performance was confirmed by the Rorschach record. The record further showed that at times he functioned as well as the average but at other times he became overwhelmed and then functioned less well. Poor functioning seemed to stem from worry about himself as unworthy and not acceptable.

The record seemed to indicate that a terrific ambition was holding him up in his intellectual functioning. On the other hand, a somewhat compulsive element seemed at times to interfere with his functioning. The compulsive trend helped to control his anxiety. He seemed to feel that things had to be just so, and if they were not he would worry.

Reports from school at this time indicated that scholastically Peter was holding his own. In arithmetic he was among the top pupils in the class.

Peter was by no means over his difficulties, as the second Rorschach record indicated. Mrs. G had gained some awareness of her role in the problem, and although she herself did not seem to have undergone any appreciable basic change her behavior toward Peter was less protective and less expressive of her anxieties about his intellectual abilities. With evidence now from Peter's school progress that he was not defective Mrs. G decided to terminate therapy at least for the present.

Kanner, in his discussion of childhood schizophrenia, states that if curiosity about dynamics cannot answer the question why certain children react schizophrenically, it can explain *how* they have come to react in the way they do. The present paper has attempted to show *how* a parent's harsh demands can limit the child's intellectual functioning to such a degree that it appears retarded.

RECAPITULATION

This paper is concerned with the psychological evaluation of children. In a general way the paper considers the child who functions intellectually at a level more or less conspicuously below the level of his abilities as measured by standardized intelligence tests. The disparity between levels of performance and capacity are viewed as an outcome of the parental anxiety which tends to prevail in our society, and which is expressed as strong pressures for the child to achieve.

More specifically, the paper deals with the child who functions inadequately and shows defective capacity in intelligence test performance, but whose potential is normal or superior. This is the child who is classified as pseudo-retarded.

The numerous possible determinants of pseudo-retardation are considered. The writer gives prominence, however, to the parental attitude and the bombardment of demands on a child who is developmentally unable to respond.

Data obtained in interviews with the parents of children the writer diagnosed as pseudo-retarded were analyzed. A finding which seems pertinent to the problem is that two particular kinds of circumstances appear to intensify parental anxiety and consequently to influence pseudo-retardation. The child was either an adopted child or was born into a family where there was a history of mental disorder either organic or functional. Two cases illustrat-

ing each of these circumstances are presented.

Fifteen percent of the children in the study were diagnosed as pseudo-retarded. The reader is reminded that a diagnosis of pseudo-retardation is made in retrospect. The frequency of cases seems conspicuous when considered from the point of view of the earlier incorrect diagnosis and its implications for the child's future. The frequency of incorrect diagnosis suggests, however, that there are many factors which may tend to obscure the child's potential even from the painstaking and experienced clinician.

In recent years there has been a conspicuous growth of interest in the mentally defective child. Currently there is a widespread movement for his rehabilitation. It is hoped that the findings of the study may help to alert the clinician to the possibility of pseudo-retardation when a child appears retarded and is an adopted child or when there is a previous history in the family of impaired intelligence.

Perhaps in a wider sense the paper is an appeal for the utmost caution in diagnosis, since low IQ and other symptoms regarded as indicative of defective intelligence often mask a normal, if not superior, intellectual capacity in a child who is struggling with other kinds of serious problems.

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Psychiatric problems in an urban university

In a recent poll of college presidents (1) nearly half of 116 college presidents were concerned with the problem of the best coordination of student counseling services and more than half felt that the major health problem in their universities concerned the emotional difficulties of their students.

The presence of psychiatrists in college and university health services has been of relatively recent origin; almost all of the literature on the subject has appeared since 1920, when Dr. Karl Menninger established a counseling service at Washburn College (2). Since then there has been a steady growth in the provision of psychiatric service to the university population, ranging from none to a full-time psychiatric staff providing treatment for students, faculty and administrative personnel. There arises the obvious problem of what sort and how much service the psychiatrist can provide and to whom. This is usually resolved as a function of the amount of money allotted for the purchase of the psychiatrist's time, the number of students seeking help and the attitude of the faculty, the administration and the medical-surgical colleagues of the health service.

Since the first articles appeared discussing mental health problems in college and universities, there has been somewhat of a change in the thinking about the clinical conditions encountered. At first the literature emphasized the relative mildness, brief duration and quick results available with treatment (3, 4, 5). Then there was expressed a note of caution to the effect that the quick relief of symptoms was frequently obtained without the discovery or resolution of underlying conflicts (6). Gradually

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other evidence accumulated indicating that the general type of problem seen was similar to that of any clinic or private practice, but that motivation was high, there seemed to be rapid improvement, and permissiveness and latitude in giving sick students a chance to stay in school and to come back were justified (7, 8, 9).

To present some of the details of our experiences we have summarized and tabulated by diagnostic categories those students whom we saw as psychiatric patients from August 1952 through September 1956. Since we provide health services for a full-time student body of some 10,000 undergraduate and graduate students, it is to be noted that we saw only a fraction not only of students with psychiatric problems, but also only a fraction of students actually receiving psychiatric treatment. The fact that there are psychiatric facilities, both public and private, available in the metropolitan community affords many students the opportunity for help. In addition, there is a large commuting population, so that it is likely that a good many emotional problems are dealt with in various ways at the home and family level.

Table 1 summarizes the diagnostic categories encountered. The great majority (78%) of students presented problems consistent with long-standing emotional difficulties (that is, character disorders in which the preponderance of the evidence is that the symptomatology is deep-seated, fixed and alterable only with considerable long-term treatment) or neurotic reactions with full-blown obsessive or depressive symptomatology indistinguishable from that seen in an adult psychiatric clinic. Our experience has been that the preponderance of our students are neither "fresh from their symptoms" (10) nor suffering from transient situational or adjustment problems which can be managed quickly. Nor is it our impression that our students are different in this regard from students of neighboring institutions. It is our further impression from our data that overly optimistic and short-term therapeutic results cannot be expected in a majority of instances.

We have used our observations to evolve a program of psychiatric care which is designed to meet the problems that arise with the facilities we have available. Psychiatric consultation and treatment is an integral part of the system of medical service made available to students. Consultations, formal and informal, are also held with our medical colleagues concerning students seen in the clinic or hospitalized in the infirmary. We are, of course, especially interested

TABLE 1

Distribution of diagnoses, 1952–56

DIAGNOSES	NUMBER OF CASES	PERCENTAGE
Neurotic reactions	112	35%
Personality disturbances	138	43%
Transient situational disorders	36	11%
Psychotic reactions	23	7%
Psychosomatic reactions	2	.06%
Neurological disorders	1	.03%
Evaluation only	10	3%

in those bodily disorders that arise in part or in whole as a result of emotional stress. Continuing discussions take place with the director of the division as to matters of policy and as to a variety of administrative problems revolving around disciplinary problems, housing problems and admission policies as well as more formal psychiatric or medical practices.

Policy concerning the admission of students who have had a psychotic episode in the past or the readmission of such students is a subject that is frequently under discussion. Our purpose is to give such students every possible opportunity for rehabilitation, and thus we pursue a liberal policy toward admission or readmission. The fact is that we tend to be guided more by the functional capacity of the patient than by the absence or presence of symptoms that are consistent with a psychotic reaction. We also see students already enrolled who develop psychotic reactions or students in whom such disorders were not detected upon admission. In similar fashion we are guided here by the ability of the student to do his work and to get on reasonably well with faculty and classmates rather than by the presence of certain of the characteristics of schizophrenia. Should the student's behavior become manifestly disturbed despite our efforts at therapy, we find it necessary usually to suggest separation from the university for medical reasons and also to suggest hospitalization.

We are also called upon frequently to help the faculty in the management of various crises. Disciplinary problems are, on occasion, cause for concern. In the matter of discipline both the university and the psychiatrist have two elements to consider. The first is that a major disciplinary infraction may be symptomatic of a significant emotional disorder and as such is to be handled with understanding rather than with an abrupt retaliatory gesture. The second consideration is that the entire university community must be considered as well as the needs and conflicts of the individual student. In carrying out our advisory function in this area, we have been impressed by the importance of fair but not inflexible rules in helping students set limits and define codes of action and behavior for themselves. From time to time we have found ourselves in the somewhat unusual position (for a psychiatrist) of suggesting that certain punishments be invoked against an individual student both as a mode of helping him with his reality-testing and as a mode of protecting and reassuring his classmates and roommates. A typical example was the instance of a Korean war veteran who beat up an elevator operator. He undoubtedly had serious emotional problems but was also behaving in an anti-social manner. Our opinion was that limit-setting disciplinary action, plus psychotherapy directed at increasing his sense of reality-testing, was in order.

Referrals arising from frictions in dormitory life pose essentially the same issues as do disciplinary problems: there must be consideration for the group as well as for the individual. The instance of the student with a severe obsessional and compulsion neurosis serves as an example. His rituals and compulsions eventually arouse the antagonism (if not the anxiety) of his roommates and yet to ask him to leave would be to end a promising career. Here psychotherapy with perhaps assignment to a single room would meet the problem for a time at least.

A special word is in order concerning those faculties which are training students in human relations—psychology, social work, the ministry, medicine and nursing. The very nature of the training and work

often confronts the student unavoidably with certain of his own anxieties. We find it useful here to meet with appropriate faculty members to discuss training methods as well as problems of individual students so that unnecessary strains are not added to those inherent in the situation. This involves a considerable amount of skill and self-knowledge on the part of the teacher.

The major proportion of the time of our psychiatrists is devoted to working with those students who are in psychotherapy. Our psychotherapeutic methods and goals have evolved gradually out of the task we face in dealing with the fact that over 75% of our patients, as we indicated in the statistical material, present themselves with long-standing and full-blown neurotic or basically characterologic problems. Emotional problems basically of recent onset, or of a situational nature, are not what we find most commonly. This has caused us neither undue alarm nor undue pessimism but it has caused us to adjust our methods and means to the realistic situation.

Essentially we attempt to do a kind of psychiatric first-aid. To this end we do short-term goal-directed and psychoanalytically oriented psychotherapy. Our efforts are directed either at the student's immediate problem or at the factors interfering with his academic work. We avoid insofar as possible undertaking investigation of the long-term aspects of the case, and this is often made explicit to the student in the first interview. He might be told that our effort would be to try to help him get along better at school and not necessarily to try to work with other matters that may be troubling him. He might also be told that more definitive care, if necessary, would have to be arranged by the student after graduation. In this way we try to focus on those symptoms or character problems that are the most immediate in interfering with his current life adjustment, and when reasonable progress has been made therapy is terminated or interrupted—but the student is invited to return if his work begins to suffer again.

Of course, long-term psychotherapy can hardly be avoided in certain instances. One student was treated for five years mainly because the relationship with the therapist was almost the only friendly relationship he had, and in fact was the only thing that stood between him and suicide on a number of occasions. He was a superior student, and hospitalization or separation from the university would have been tragic. This particular story had a happy ending: after earning a graduate degree the young man was able to embark upon a promising teaching career in a secondary school and is doing quite well in other areas of his life. But even in this case the focus was constantly on the problems at hand and not on the deeper psychopathology that was obviously there.

One particular group deserves mention. These were students of good or superior intelligence who came to our attention because they were doing poor work considerably below their potential. At first blush the psychopathology in many instances seemed clear. Some of these students were at college at the insistence of their parents; for others, not working represented an important aspect of adolescent rebellion with attendant self-punishment (in the sense of hurting oneself in order to hurt the parent). Our expectation at first was that these students would readily and quickly be helped. This was an overly optimistic expectation. In many instances the work inhibition was so severe and the motivation so poor that they carried over into the therapeutic relationship as well, and the student came for

therapy with the feeling that it was the doctor's job to make things right again without any particular effort or contribution on his part. Before these students particularly we held the reality: we would help with psychotherapy but it was unlikely that the mid-term examination would be passed or the term paper written in any magical way. The student himself would have to do the studying and the writing. Many of these students left school of their own accord or were asked to leave. Psychotherapy was usually not effective quickly enough to save a failing student in this category.

From time to time it has proved quite helpful to ask parents to come in, perhaps to explain that psychiatric care was needed or perhaps to attempt to help the parent see that the parental pressures or demands were related to poor performance. Parents were always notified and consulted if hospitalization were being considered so that they might exercise the option of taking the student home for care through the family physician or the community psychiatric facility.

Inasmuch as our student population far outruns our facilities for providing treatment at the university we have made disposition in various ways. We handle as many as we can; those who can afford it are referred for private care; some are referred to clinics, still others for psychoanalysis. These dispositions are possible because of the psychiatric facilities available in a large metropolitan community.

SUMMARY AND CONCLUSIONS

1. Our experience with psychiatric problems in a large urban university for the years 1952–56 is reviewed.

2. Most (78%) of the students whom we saw presented emotional problems consistent with long-standing emotional difficulties: full-blown neuroses and character disorders. Only 11% of our diagnoses were in the area of transient adjustment problems.

3. Psychotherapy with students is our basic and major activity and is an attempt to do a kind of psychiatric first-aid. Our focus and emphasis is on the immediate problem with the goal being more adequate ability to meet the current life situation rather than any major attempt to deal with underlying psychopathology.

4. Consultation with medical colleagues, faculty members, administrative officers and parents is also an important aspect of our work.

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The American family in crisis

Of all people, those that are concerned with mental health should be, or so it seems to me, the very first to embrace within their concern the community as well as the individual. They should labor under a compelling need to inquire—how healthy is the community, and also, how much and in what way does the community contribute to the breaking down of the individual? They should, in other words, bring social as well as intra-psychic etiology into the picture.

And yet, it isn't the community *per se* that calls for scrutiny, but rather its social integer, the family. According to the famous anthropologist Claude Lévi Strauss, "the family, consisting of a more or less durable union, socially approved, of a man, a woman, and their children, is a universal phenomenon, present in each and every type of society." [1]

Historically and culturally, the family *is* the social integer of society. The family is the reflex of, the begetter and the begotten of the community. In studying the community, we can begin with the family, even though, as we need to note, the community is more than an aggregate of the families it embraces.

It is the family I would consider with you, and not the hypothetical or universal family as defined by Lévi Strauss, but rather the American family, which, as I see it, is in a state of crisis. I plead with you not to pick a quarrel with me over the issue, is

I. Galdston delivered this address May 9, 1957 in Philadelphia before Pennsylvania Mental Health, Inc. In composing this paper he drew substantially upon several of his earlier essays: *The Matriarchoid Family, Social Work How Come* and *How Social Is Social Work.*

[1] Harry L. Shapiro, *Man, Culture and Society,* New York, Oxford University Press, 1956.

there such an organism as the American family? I know how this matter is "teased to rags" by the sociologists, who only particularize and never generalize about the family. I can even sympathize with their scruples, and agree that there are really only nascent families, maturing families, upgrading families, and so forth. Yet for my purpose, it is safe and sound to postulate the existence of an American family, for what I treat of is not a parochial variant, but an all-pervasive dynamic, which embraces and affects us all. It is a socio-economic, cultural and psychological disorientation to which all of us are subject, and which is most patently affecting the American family.

Our experts on communication advise us that a thing is not a thing until you've named it. I've therefore named it. I've named the crisis of the American family as the Menace of the Matriarchoid Family. The American family is losing, has lost, its patriarchal pattern, and is becoming matriarchoid in character. The term *matriarchoid* is a neologism. I intend it to mean "resembling but essentially different from matriarchy." The term is my own, but I share with a few others awareness of the crisis that it labels. Several sociologists and psychiatrists have taken note of this change in family pattern. You have, I am sure, come upon the term *momism,* coined, I believe, by Philip Wylie, and first used in his book *A Generation of Vipers.* David Levy, a pioneer in this field, has studied the subject obliquely, dealing mainly with the over-protective mother and her psychological effects upon the family. Sorokin has skirted about this thesis in his embracing diatribes on current society. The Gluecks in their studies on juvenile delinquency have provided us with telling data on the evil consequences of the familial change. Parenthetically I would add that in several of these works Mother has been made the scapegoat, and womankind in general has been made the target of blame. It's Adam's old trick of blaming Eve and I'll have no part in it. As I will undertake to show later, it is woman, even more than man, that has suffered by this change in familial pattern, although in truth I do not see how the suffering of the one sex can fail to involve and affect the other.

If you require me to describe or to define the matriarchoid family, I can do so only in negative terms. Its predominant features are the abandonment and denial of the patriarchal patterns, values and mores. The matriarchoid family is in *status nascendi.* What its ultimate features may be we cannot anticipate, but its current pathogenicity is all too clear. I will revert to this later. Here I need to define what I intend by patriarchal patterns, values and mores.

Allow me first of all to go on record that I am not a defender of the patriarchal family. My role is that of an expositor; not that of a pleader. I do, however, believe that what was originally a descriptive term has been converted of late into a term of opprobrium. The patriarchal family is too commonly envisaged as a marital group, in which the wife and children are tyrannized by the husband and father. No doubt such family groups do exist, but I would rather, I think, describe such groups as "male tyrannized," or, as not infrequently happens, as "woman tyrannized" families. Historically, that is, as far as historical data are available (and I must add that the data are scant and the conjectures multiple), the outstanding characteristic of the patriarchal family is not male tyranny, but rather the domestication of the adult male. The patriarchal family gave rise to "husbandry," that is, to the more or less life long "enslavement" of the male to the arduous task

of providing for the care of his marital partner and the defense and upbringing of his children. This association and commitment of necessity involved governance which, in turn, in some instances no doubt, led to tyranny—for, as Lord Acton observed, all power corrupts.

The extent and degree of masculine authority no doubt varied from age to age, but a complete and abiding arbitrary mastery of man over woman is hardly conceivable, not only for the reasons so pointedly exhibited in Lysistrata, but also because all males are perforce the sons of mothers.

The patriarchal family came into being as a result of the economic progressions of primitive society. "One of the reasons why the patriarchal family is not to be found in lower cultures," wrote Briffault [1] "is that it (the patriarchal family) is founded on property, and that the dominance of the husband in that family and the subordinate position of the wife rests utlimately upon the economic advantage of the former and the economic dependence of the latter." We do not know precisely when the patriarchal family became the norm among European peoples. For our purpose it suffices to appreciate that the patriarchal family has existed for a long time, for a time longer than the span of recorded history. To the economics of this family pattern, to its expanded and planned husbandry, we can trace almost the entirety of our socio-cultural history and heritage.

Both the relationship and the economy of the patriarchal family are contractural in nature and committed in spirit. Planning involves coordination, pledged promises and obligations which are to be fulfilled. Failing of these, both plans and planners face inevitable ruination.

A vast portion of our ethos, and much of our socio-cultural heritage revolves about contracts, pledges and commitments. It is not for naught that one of the earliest sociologists, Jean Jacques Rousseau, titled his classical although naive masterpiece, *The Social Contract.*

This is not, and to my mind, never has been, a man's world. But for many millenia it has been a "patriarchal world." I am not referring solely nor mainly to man's position in the family. I mean rather that our value systems have been patriarchal—that is, reflexive of the pattern and purpose of the patriarchal family. We are likely to describe them as masculine values or virtues—values such as work, order, discipline, insistence on the fulfillment of pledge, promise and contract, and so forth. But they are neither purely masculine nor are they pristinely native to him. They are virtues, or values if you prefer, which have been assessed as such in the operational relationship of the patriarchal family.

It would be an enormous task to trace the many ways in which these patriarchal values are manifest in our traditions, laws, customs, habits and arts. These are so native to us that we needs must hold them off at a distance, by an effort of deliberate intention, to examine them. Consider, for example, the most obvious instances, those of style and dress, and our sense of the beautiful in the human form, both male and female; the arts graphic and plastic, literature, poetry, the drama, and above all our sacred texts, the Bible and its commentaries, our ecclesiastic history, its numerous rituals and traditions—all these historically carry the patent imprint of patriarchy.

This I believe to be historically true. But the patriarchal family is rapidly disintegrating, and in that process we are experi-

[1] Robert Briffault, *The Mothers,* New York, Macmillan Co., 1931, 158.

encing and witnessing a negation of those patterns, values and mores on which and by which our multi-millenial culture has been structured and buttressed. The effects are witnessed in social misery and what collectively must be termed socio-cultural delinquency. These are the challenges which confront the psychiatrist in the lives of those who turn to him in search of sanity.

Society is sick, and its morbidities are most clearly exhibited in the family. Juvenile delinquency, divorce, alcoholism and drug addiction, homosexuality, frantic promiscuity, are widespread. They are not the result of the change in the family pattern; they are rather the concomitants thereof. They issue from the same complex of forces which has so disruptingly affected the family structure. Among these prevailing social morbidities none is more terrifying than the anarchy of youth—wrongly termed juvenile delinquency. I find this term most objectionable, because it misleads and corrupts our understanding of the faults involved. A delinquent is one who has failed in the fulfilment of an obligation or a duty. But this presupposes both knowledge and wilfulness. To prove a delinquent I must both know and wilfully fail to meet my obligations. But if I do not know my duties nor my obligations, if I do not know them in the compelling manner of an indwelling conscience or ego ideal, how am I then to be adjudged a delinquent? At most I deserve to be named no worse than an ignorant, uncultivated or asocial fellow. And that's precisely the point. Our young at times do not know their duties and prerogatives at the cognitive or informational level, because they have not been informed (the ignorance of patients is often appalling) or, knowing of them, their knowledge is not supported or activated by the affect charge of an ego ideal. They are without a conscience, super-ego, ideal ego or ego ideal. Freud has taught us that the super-ego represents the introjected or incorporated father image. In the matriarchoid family there is no conscionable father image to introject. I believe that the societal ethos contributes no less to the structure and content of the super-ego than does the father personage. But as I have already observed our very ethos is growing more matriarchoid—and less patriarchal.

The anarchy of youth is more embracive and meaningful than juvenile delinquency, the latter being a term heavily freighted with legalistic implications. The anarchy of youth is to be witnessed even in the absence of crime or violence.

I cannot here elaborate upon the other instances of social delinquency which I named—divorce, alcoholism, drug addiction, homosexuality, etc. I must rather turn to the question—*What is behind this change?*—What is the derivation of this pervasive dynamic that has resulted in such a profound cultural and psychologic disorientation? The answer is rather simple but too frequently misconceived. It is our changed and changing economic and industrial system. What comes to mind with this phrase? Most commonly the marvels of modern technology, the steam engine, the electric dynamo, the telephone, radio, television and so on right down to atomic energy and automation. But it is not these technological marvels that I have in mind when referring to our changed and changing economic and industrial system. I intend something more revolutionary, more fundamental, more fateful. I mean the advent of the modern industrial manufacturing system. I doubt that mankind in its long existence on this earth has ever before experienced so profound an ecological disorientation as that effected in the advent of modern industrialism. Only the mastery

of fire and the conquest of the metals in the bronze and iron ages can be conceived to have so profoundly affected the lives of mankind as did the industrial revolution.

We are all aware of and indeed are surrounded by the technological marvels which the industrial revolution has yielded. But in the main we are unmindful, except in a vague and possibly troubling way, of the other yields of the industrial revolution, those involving man as a psychologic, social and spiritual creature. Let me touch upon these "other yields" and detail a few of them. The industrial revolution was vastly more than merely industrial in nature. In effect it produced the most cataclysmic social disorganization man has experienced since the time Prometheus, by robbing the gods, made him a gift of fire. For one—it distanced man from the earth. For thousands upon thousands of years (the estimate is half a million), man lived in and on, but ever in the most intimate contact with the earth. He lived off, or worked, the soil or the sea, or, if he chanced to be a craftsman, merchant, soldier, minister or king, he was but a pacing distance from those who did. As late as the fifteenth century eleven-twelfths of the population of England were employed in agriculture. Now I will not dwell upon the tutorial effects of such proximal and intimate relation with the earth or on all that it can teach a man of life and living. I want rather to single out one disastrous effect that followed on the separation of man from the earth. He suffered the chronic starvation of malnutrition. That is not the same as the starvation of want or of famine. It is much worse. To this alienation of man from the immediate and native sources of his food may be charged, in a very large measure, the major epidemic diseases of the nineteenth century, diseases such as tuberculosis, typhoid, cholera, scarlet fever, diphtheria and the infant diarrheas, and of such chronic disorders as rickets and chlorosis. The nineteenth century man was not a healthy specimen; and a great deal of his ill health can be traced to his malnutrition.

I have underscored the separation of man from the earth mainly because the fact itself is so little appreciated and because its effects are so little realized. To my mind, however, even more disruptive were the effects of the industrial revolution upon the homestead, the family and the interrelations of man, woman and child. The homestead, which in its more ideal pattern embraced three co-existing generations, was an institution of far-reaching effects. It was in substance a school for living, wherein the young were indoctrinated by practice and precept in the techniques and wisdoms requisite for making a go of life. It was the repository of a man's enterprise; his security against advancing years and failing strength; his heritage gained and his heritage transmitted. It gave the testament of endurance, of meaningful continuity, to the succeeding generations. True, it exacted the performance of duty and the fulfilment of obligation, but it redeemed the travail of both in the rewards that were attested in the prospering family. Above all, it gave clear meaning, a transparent rationale, to those virtues which the moralists taught—the virtues of honest husbandry and of good will.

The industrial revolution disrupted the homestead, negated the rationale for its being, and created a world inimical to its very existence.

The industrial revolution weakened the structure and dissipated the native functions of the family. Since time immemorial men and women were more bound in union by the mutuality of services rendered to each other and to their progeny than by the

warm but evanescent charms of romantic love. The family was not merely a conglomeration of persons but rather a productive organization, a working union. With the industrial revolution, and because of it, most of the productive functions of the family organization were taken over by other organizations. The intrafamilial "mutuality of services" has been reduced almost to the vanishing point.

One of the warrants for union in marriage of men and women was, as it remains, the desire for progeny. But whereas in time past children were an asset, in the real as well as in the affectional sense, they have become more recently, if not entirely a liability, certainly something of a luxury—to be indulged in circumspectly. The child too has suffered a severe dislocation in its intrafamilial relations. During its youth it is now largely a supernumerary. It has no organic, functional role in the current familial scheme of things. This is especially the case with the urban child. Save for its school work the child has little to do, and that little is of a make-work character. Contrast this with the many chores which the child performed in time past, and still performs in some of our rural homes.

Nowhere, however, are the disruptive effects of the industrial revolution more clearly reflected than in the degradation that woman has suffered in her familial position and function. For thousands of years woman was the mainstay of the family. She was wife and mother, nurse and teacher. She spun the yarn and wove the cloth. She tailored; she gardened for the kitchen and the medicine chest; she it was who molded candles, preserved foods against the winter seasons, made soaps, cooked, baked, laundered and tended to the hundreds of functions and details that were so vital to the maintenance and the flourish of the family. She bore sons and daughters, to be of aid to herself and their father, to be their pride, their consolation and their support. Doubtless she worked long hours and hard, but for all this she had her rewards, the greatest among them the secure knowledge that she was needed and wanted; that she was indispensable in the scheme of the living pattern. There was for her, too, the sense of accomplishment, the satisfaction that comes with the fulfilment of the primal urge to create, to dispense of self in the process.

Thus it was for thousands of years. But thus it is no longer. One after another of the woman's functions, of her utilities in the home, have been taken from her—first by the machine and then also by the mercantile, commercial and social agencies. Now she neither spins nor weaves. She has neither greens nor herb garden. She does not bake, though she may yet cook. She has been, as some of our feminist and liberal friends say, and with such eager enthusiasm, "she has been freed of the yoke of household chores." She is a free woman —free for what? To the man from Mars, for he alone could be considered a true outsider, it would appear that woman, so largely deprived of her ancient prerogatives, is free to seek retribution, and is doing so in a mighty wrath of frenzied aggressions.

The socio-economic changes to which I trace our social disorientation have taken place in our sphere during the last 150 years, and this is but as a moment in the long span of man's habitation on this globe. We then must ask: Can the primal hungers and wants of men and women be readapted to fit this changed and changing world? Can we with impunity deny, gainsay, block out, impede, divert that *élan vital,* that upsurging drive that lifted man out of the

primal ooze and that has through the eons of time brought him to the forefront of creation? Can we, without paying a fearful price therefor, meddle with that order of relations between men and women that has in the span of time yielded us love and song, the plastic arts, poetry, the dance, the culture of beauty, of form and color, of adornment, of perfume; that has given us courtesy and grace, manners and spirit; that has fostered home and friendship, and the strong bonds of blood kinship, the *Anlage* of all that is civil and civilizing? Can we? All the available evidence speaks against it: witness the so-called battle of the sexes, hate and love, and momism.

I have referred also to the negation of the ancient wisdoms. I intend by this decline in prestige and power of those institutions whose primary function it has been to indoctrinate man in the habitudes and practices of altruism. I mean primarily religion and the church, intending by the latter every order of congregation and place of worship, although among the indoctrinating institutions one could and should include also the enlightened professions and the universities.

Few among us today can fully appreciate the role that the church and the synagogue played in the lives of our own ancestors. The place of worship served for more than worship. It was where acquaintances were made and friendships were engendered. It was where romance insinuated its sparkling, bright spirit, to give temporal pertinence to the timeless verities. It was where courtships were often first inspired and ultimately sanctioned. The church was an instrument of charity and of mercy. It succored the orphan and sustained the widow. It cheered the sick and consoled the bereft. It tempered the galling guilt no less than it goaded the slothful conscience. It reconciled the estranged, and fostered justice. It gave refuge to the persecuted, and aid to the abused. It was, in a word, a realm apart, wherein by his own efforts, and with the aid of the anointed, man could reconcile the temporal with the timeless, the mortal with the immortal, the particular with the transcending, and thus achieve an effective relationship with both the immortality antecedent to his earthly advent and that beyond his demise. The church helped our ancestors to appreciate, even when they did not understand.

The church was once the place where music was written and rendered, where the staged spectacle taught both the doctrine and the mystery, where the painter adorned the walls with his graphic portrayals of Old and New Testament scenes, where calligraphy was practiced and taught, where the young learned their alpha and beta, and the more advanced the cumulative knowledges and the wisdoms of the ages. Here, in a word, the liberal arts were cradled and nurtured. The church was to its congregation, to the community, club, theater, opera, museum, library, school, welfare agency, nursing service, foundling home, funeral parlor, and much, much more besides.

Man is a creature that lives by values, no less than by bread, and of late too many of his traditional values have been cast into doubt. In the cataclysmic upheavals of two world wars, goodness, love, charity, mercy, truth, humility, brotherliness, have been violated and mocked. There is current a highly organized, energetic and cunningly resourceful propaganda which makes the homely virtues and the religious persuasions and faiths of our fathers appear like a compound of neurotic anxiety, infantile delusion, political-economic naiveté and mean escapism. Many who are caught in the tension field of this propaganda seek refuge in doctrinate bigotry; hence the re-

surgence of orthodoxy in morals and religion.

Now I must hasten to bring my exposition to an end, and to summate briefly the burden of my argument. My original proposition was to the effect that an effective resolution of the mental hygiene problem requires not only persons, tools and places but also, and primarily, a healthy community.

It is my conviction, supported by numerous data, that the contemporary community is not healthy. I call in witness the data bearing on what I have labeled "the social delinquencies." Positing the family as the integer of the community, and in explication of the crisis involving and affecting the American family, I have endeavored to show how and in what ways it is losing its patriarchal pattern, values and mores, and is passing into what I have labeled the matriarchoid state.

I have traced this change to the industrial revolution and to its numerous ecological, social and psychological disorienting effects. In essence, the industrial revolution has disjointed the family. It has disrupted the obligatory, symbiotic co-existence pattern of men and women and has rendered it merely facultative and optative. It has weakened the meaningfulness of the child as fulfilment of adult existence.

I have expounded all this not in the spirit of a Jeremiah. I call neither for repentance nor for a return to the faiths and ways of our forefathers. That is beyond and behind us all—for all eternity. We must rather seek for new ways, for an effective reconciliation of the abiding needs of man with the new ways and needs of our changed and changing world. But seek them we must for they will not come to us of themselves. We must seek them in the light of a clear understanding of the nature of the crisis confronting the American family. It is to this end—the illumination of the nature of the crisis—that I have directed my exposition.

LEONARD T. MAHOLICK, M.D.

Mobilizing therapeutic potentials in the community

Many communities are faced with the ever-present "three-ringed crisis" in the form of maladjustment, ill health and chronic dependency—for which communities are spending fantastic amounts of money and about which little is being done in an organized, unified manner. In 1952 the expenditures for health, welfare and recreation in Columbus, Ga., totaled approximately $4,500,000. It has been estimated that for adjustment and health services alone during this same year over $2,500,000 were spent on a relatively small number of families (1).

It is believed that about 6% of the families are costing the community millions of dollars and that this same group is getting the lion's share of the community's services. This figure, 6%, seems to be significant. Although not verified locally, detailed studies in such widely separated communities as San Mateo, Calif., St. Paul, Minn. and Hagerstown, Md. revealed that in a given month 5.8%, 6.1% and 5.9% of the families of the respective communities absorbed a very high proportion of the communities' services. These families were called multi-problem families because they had a combination of two or all three of the problems of maladjustment, ill health and dependency. Analysis of the 6% families in St. Paul indicated they had had the services of a large number of agencies recurrently over long periods of time. More significantly, the histories of these families indicated that the families from which they sprang had presented a similar picture of problems and needs (2, 3).

Here, then, is a clear-cut indication of the generation-to-generation sequence of recurrent problems. Most of us working on

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a community level sooner or later vaguely suspected this. For the first time, as a result of detailed community studies, our suspicions have been verified. If this is true, we are forced to ask the next logical question, "Why does this prevail?"

I believe there are several factors which account for this. First of all we must look at the agencies in the community. We quickly note that they, too, have many needs and problems of their own. Paramount is a lack of just about everything—a lack of facilities, of an adequate budget, of well-trained and experienced personnel. Unfortunately, but often true, there is a lack of appreciation and understanding on the part of the public. Too frequently the agencies are overloaded with cases and undermanned. Added to this is the fact that pressure for service is great. Soon the will to resist is lost. Are we really amazed at the patchwork that must of necessity be done frequently?

Probably a more basic difficulty has to do with the fact that while the agencies often are faced with a multi-problem family they frequently offer single-problem services. An acute situation, problem or symptom is dealt with and, once this is handled, the agency moves on to the next "emergency." Sometimes only one member of a family presents his problem to one agency at a time. He may go to a different agency with a different problem the next time. In addition, if he is not satisfied with the results he gets in one agency, he is free to run to the next and to the next. Even worse is the fact that different members of a family may go to different agencies with different problems at the same time.

To date most communities seem to be powerless to combat this waste of time, effort and money. At best a piecemeal job is done while the basic underlying total family problem is ignored.

A third factor is "agency isolationism." In many communities agency attitudes are very poor. Personality clashes exist. Petty jealousies develop. Rivalry is keen and sometimes disastrous. Some agencies are insecure regarding their role, function and place in the community. These conditions can lead to agency isolationism. As a result each agency tends to act independently with its own separate and unique functions to perform and not as a part of a unified, co-operative team.

The last factor is the absence of a psychiatric team consisting of psychiatrist, psychologist and psychiatric social worker.

With the establishment of the Bradley Center in Columbus this last factor has been removed locally. The staff has the necessary facilities and basic professional talent for making a family-oriented diagnosis and developing a comprehensive treatment plan for family disorganization and maladjustment. Furthermore, owing to the understanding and support of a board which has long-range goals in mind, the center is in a position to devote up to 30% of its time to community services involving consultation, education, prevention and research.

The policy of the center dictates that it shall function in two broad areas: (1) meeting the emotional needs of the individual and (2) meeting needs as they exist in the community.

Figure I indicates how the center has mobilized its resources for meeting the needs of the individual. If one out of every ten individuals will need some form of psychiatric treatment during his lifetime, it is estimated that 23,500 people currently need help in the Columbus metropolitan area. There can be little doubt in anyone's mind that any unit which tries to meet some of these needs is rendering a very worthwhile service. We could

easily devote our entire time to this effort. However, let us look at the situation more closely and realistically. If the center were able to see an average of 235 to 250 cases a year successfully, it would take at least the next century to meet all the needs estimated to be existent now. And this would be on the condition that everything stood still for the next hundred years! To attempt this would be both fantastic and ridiculous. Even if a complete psychiatric team existed in the school system, in the courts, in the public health department and/or under the auspices of United Givers, the combined efforts of all could not possibly meet these needs.

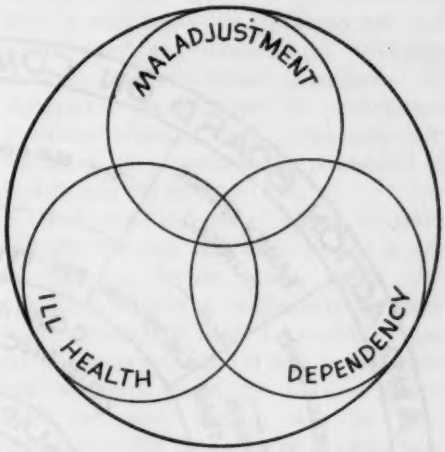
More fundamentally, if we confined all of our efforts to the sick individual, we would not pay much attention to the culture which is giving birth to sickness. To achieve a healthy society we need healthy personalities, but healthy personalities also

FIGURE I

Mobilizing the center's resources for meeting the emotional needs of the individual

FIGURE II

Major community problems



THE THREE-RINGED CRISIS

FIGURE III

Major human problems: the usual present day approach

FIGURE IV

Mobilizing community resources for united action

require a healthy society. There is a reciprocal dynamic relationship between the two (4). We therefore believe we have a responsibility not only to the individual but to the community at large. We shall have to force ourselves to think and do differently if we are going to meet successfully the three-ringed crisis (see Figure II).

We are proposing a plan to mobilize all of the community resources in a united effort to defeat these three potent enemies. Figure III illustrates how we are at present

set up to cope with the problems. We have a very loose, disjointed organization. There is no over-all plan, no co-ordinated effort, no unified program. Figure IV illustrates how it might be possible to pull together all the existing forces. Our plan proposes the establishment of two new units: (1) a Community Guidance Council made up of professional delegates from each of the community agencies and other responsible groups and (2) a Planning and Action Board made up of civic delegates from each of the boards of the same agencies, from other civic groups and also from the community at large. These two new units would have as their primary function: (1) continuous over-all planning and (2) the implementation of an effective, unified program. Working together these units would have available at all times a total and complete picture of the community's needs, what is being done to meet the needs and what isn't being done. In this way all of the boards and all of the professional people of all of the agencies are drawn into close and direct contact with each other. With this kind of alliance a new, powerful force is created in the community for meeting the existing needs.

It must be remembered, however, that neither the Community Guidance Council nor the Planning and Action Board is a new direct service unit. Rather, the council will act as a co-ordinator and guide, giving qualitative help and over-all direction to the already established service units in the community. In addition, it must be made clear administratively that the identity and autonomy of each agency is preserved. Each service unit will become a distinct part of a unified whole. The board will be a prime mover in effecting needed changes in the community.

A program must be developed. However, it should be the result of group effort. Its form and content should reflect the thinking and planning of everyone. There is little doubt that it would of necessity cover such areas as: (1) identifying who is sick, what the problems are and where they are located; (2) screening methods; (3) evaluation procedures; (4) therapeutic management; (5) professional in-service training and community-wide education; (6) prevention; (7) promotion of health, and (8) research (5, 6).

What about the cost of such a venture? Initially the cost will be expressed solely in terms of interest, time, energy, cooperativeness and a willingness to work with a democratic spirit on problems that are of concern to all. It will be no small task to break down the barriers which hold us apart, and it will be difficult to grope for new ways of thinking and doing. We must learn how to work and live together effectively if we are going to conquer the problems which surround us.

In Columbus, under the leadership of the Bradley Center, two conferences were held on September 26 and October 25, 1956 at the center. Forty-three civic and professional leaders representing 19 different agencies and groups, including the city and county commissioners, Board of Education and Board of Health, discussed the three common community problems. The group decided unanimously to establish: (1) a professional Community Guidance Council and (2) a lay Planning and Action Board. The Community Guidance Council for Family and Social Problems was established officially on November 8 and a chairman, vice chairman and secretary were elected. The Planning and Action Board is to be created shortly after the council has had an opportunity to establish itself. Regular weekly conferences are now in session. We have just begun, but we are moving!

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An approach to the selection of patients for group psychotherapy

I. In the course of their experience in an out-patient mental hygiene clinic the authors of this paper have become convinced that group psychotherapy is the treatment of choice for a substantial percentage of patients whose problems are susceptible to clinic therapy of any type. By group psychotherapy we mean the process which takes place whenever people are gathered together for the consideration of personal emotional problems with the purpose of alleviating them, in the presence and with the aid of an individual skilled in both the understanding of the individual personality and the patterns of human interrelationships and group interactions.

In this paper certain criteria are discussed which have been found useful in identifying those individuals for whom this approach offers specific benefits as well as those who are unable to utilize it. In addition, the selection of patients from the standpoint of the requirements and limitations of the group itself is considered. These criteria are based on the authors' analysis of the unique characteristics of this form of therapeutic experience. A standard method for describing various kinds of therapy groups is proposed. It should be emphasized that problems of therapeutic technique have been excluded from consideration here except where they are directly pertinent to the selection of patients.

The clinical setting is always an impor-

The five co-authors of this article are all members of the staff of the state mental hygiene clinic at Berkeley, Calif. Their paper was presented in October 1955 at the western section meeting of the American Group Psychotherapy Association.

tant factor in determining which of several possible therapeutic orientations is chosen. The authors are members of the staff of a state-supported mental hygiene clinic offering psychiatric diagnosis and individual and group therapy for adults and children. As the only such facility serving an urban and rural population of 1,500,000 we continually face a far greater demand for our services than our professional staff of seven full-time workers can possibly meet. Thus it has become our policy that all treatment offered be limited in intensity and duration.

In our attempt to offer psychotherapy to a maximum number of patients, the group approach was instituted experimentally in 1948, shortly after the opening of the clinic. Since that time group therapy has gradually become an increasingly important part of the clinic program. At present, under the direction of the group therapy consultant (J.E.N.), an average of six or seven therapeutic groups meet weekly, these comprising almost two-thirds of the adult patients seen for extended treatment.

Members of the clinic staff concerned with this effort have met regularly to study the group process. In the course of these meetings it became apparent that certain empirically derived yet unverbalized clinical criteria were being applied in selecting, from among the applicants for therapeutic services, those who would be offered group psychotherapy. Further discussions resulted in a crystallization of these concepts in a more systematic manner, which made possible their more efficient application in the intake process. Subsequently we have become aware that other workers have arrived independently at somewhat similar conclusions. We refer especially to the papers of Freedman and Sweet (1), Geller (2) and to parts of the work of Bach (3). Hulse (4) and Slavson (5), while agreeing in part with our findings, are of course working under different circumstances and with different goals, which make direct comparisons difficult.

II. We are very much aware that criteria developed in this clinical setting might have validity only for our own or for nearly identical situations. In addition we have frequently encountered difficulty in making maximal use of the reports of some other authors who have failed to delineate specifically their particular settings and methods. We are therefore attempting to describe our therapeutic groups in a comprehensive and systematic manner with the primary purpose of providing adequate information about our own approach. We would also hope that a more general use of some such method of evaluation might reduce confusion in the literature and lead to more profitable communication among workers in the field.

Our description is a modification of a classification introduced by Dreikurs and Corsini in their review of twenty years of group therapy published in the February 1954 *American Journal of Psychiatry* (6).

For purposes of clarity we have divided it into two sections, dealing first with administrative structure and then with internal group functions.

As can be seen, our program is under the auspices of a tax-supported out-patient general mental hygiene clinic. Fees are set individually on the basis of ability to pay and are identical with those charged for individual therapy. Our typical group is composed of 6 to 8 men and/or women usually between the ages of 20 and 40. They meet for one hour weekly for a 6-month period, following which they may be reassigned to another group or to individual treatment. The therapist may represent any of the three professional disciplines at the clinic, and there is usually a non-par-

PLATE 1

Administrative structure

1. *In what clinical setting is therapy being done?*
   • Outpatient, tax-supported general mental hygiene clinic.
2. *What fees are charged?*
   Graduated depending on income; identical with fees for individual therapy.
3. *How many patients are usually assigned to each group?*
   We may assign 10 to 12 patients initially, although the usual working group has 6 to 8 members.
4. *Are both sexes included in the groups?*
   Some are exclusively male or female, others are mixed in sex.
5. *What is the average age range of the patients?*
   Usually between 20 and 40 years.
6. *How long does each group therapy session last and how often does the group meet?*
   Approximately one-hour sessions once weekly.
7. *For how many sessions does a group usually meet?*
   24 sessions (a 6-month period) following which there may be reassignment to another group or to individual therapy.
8. *Which staff members act as therapists?*
   Psychiatrists, psychiatric social workers and clinical psychologists. (Staff members usually, rather than trainees.)
9. *How many therapists are assigned to each group?*
   Usually one therapist and a non-participant observer.
10. *Do patients receive individual therapy concurrently with group?*
    Only rarely, primarily in crisis situations.
11. *What diagnostic categories are represented among the group members?*
    Usually a mixture of psychoneurotic, psychophysiologic and personality disorders. Occasional ambulatory schizophrenic reactions.

• Answers refer to groups at the Berkeley State Mental Hygiene Clinic.

ticipant observer-recorder. Patients in group therapy are not seen individually except in connection with specific crisis situations. Diagnostically our patients are usually classified among the psychoneurotic, psychophysiologic or personality disorders with occasional ambulatory schizophrenic reactions. All diagnoses are usually represented in a given group.

As can be seen in Plate 2, we illustrate the functioning of our groups through the device of creating a series of continua upon each of which we assume a position relative to the theoretical extremes. We believe

PLATE 2

Group therapy classification

I *OPTIMUM GOALS OF THERAPY*

Impart information	Allow catharsis	Reappraise reality	Build new defenses	Attain insight	Change basic personality
				•	

II *ROLE OF THERAPIST*

A. TYPE OF THERAPEUTIC ACTIVITY

Corrective, educational	Supportive, suggestive	Clarificative, interpretive
		•

B. AMOUNT OF THERAPEUTIC INTERVENTION

Constant	Frequent	Rare
		•

C. NATURE OF THERAPIST'S DIRECTION

Chooses topics, lectures	Calls on patients	Restates content	Questions meaning of behavior
		•	

III *ROLE OF PATIENT*

A. TYPE OF ACTIVITY ENCOURAGED

Listening	Discussing	Emotional involvement
	•	

B. TYPE OF INTRA-GROUP RELATIONSHIPS FOSTERED

Therapist-Patient 100%	Patient 50% Therapist 50%	Patient-Patient 100%
	•	

IV *CONTENT EMPHASIZED IN SESSIONS*

Mental hygiene principles	Problems of adjustment	Personal emotional difficulties	Group interactions	Fantasies, dreams
		•		

• Refers to the position on the continuum occupied by our groups.

that patients in our groups achieve some modification of their defensive structure and certain insights into the origins of their current difficulties (I). In general, however, we do not expect basic personality changes.

The therapist in our groups tends to limit his therapeutic intervention to clarifying and interpreting the material produced by the patients. He rarely educates or reassures them. He remains relatively silent and allows the group considerable latitude in the selection of topics for discussion (II). He often raises questions which will call the groups attention to significant content or behavior.

The patient, on the other hand, is encouraged to become emotionally involved in the group process, with relationships among the group members being the primary focus (III).

The discussions usually deal with personal emotional difficulties and, secondly, with their expression in the group interaction (IV).

III. We feel that the group therapeutic process by its nature possesses certain unique characteristics which may influence both positively and negatively the selection of patients, and hence a consideration of these must be incorporated into the process of evaluation.

We believe that an essential point of difference between a therapeutic group and a purely social group results from the initial expectations of the members. Each individual comes with some anticipation that his symptoms will be relieved and with at least a minimal awareness of the contributory role of personal emotional problems. These factors plus the presence and activity of the therapist create a permissive atmosphere which encourages the free expression and acceptance of feelings. In contrast to the individual therapeutic situation there is less specific pressure on each member to reveal anxiety-provoking material. In some cases, competitiveness may stimulate early self-revelation; in general, however, individual psychological defenses are adequate to prevent premature and overly disturbing insight.

As the group continues to meet, relationships form among the members and with the group therapist similar to but lacking the intensity of the transference phenomena present in individual therapy. Particularly prominent are feelings analogous to those previously experienced in the sibling situation in childhood. The group also provides an ideal setting for the appearance of typical interpersonal defensive maneuvers which have an emotional rather than an intellectual impact. Denial of the existence of such behavior is more difficult under these conditions.

It is our opinion that individual members tend to utilize the group discussion according to their current level of psychological development. For example, some patients gain reassurance simply from learning that their problems are not unique; others become aware of their characteristic defensive patterns from observing their reactions to fellow group members. Finally, the group serves some individuals by providing an opportunity to compare and contrast their own perceptions of reality with those of others.

IV. As a result of these considerations we have selected certain categories of patients who seem to respond to our therapeutic groups.* One category includes those who gain primarily from the permissive atmos-

* In the discussions which follow, the capital letters in parentheses refer to specific clinical examples which may be found at the end of each section.

phere or relative lack of pressure in the therapy situation. These include individuals who are unable to use brief individual therapy because of inarticulateness and lack of social aptitudes but who can participate in group therapy even though non-verbally at first (A). To others who are quite fearful of intimate individual relationships, group treatment offers a way of safely experiencing the satisfactions and rewards of social and emotional interchanges.

Secondly, there are those patients who develop transference involvements which become unmanageable in a relatively brief individual therapeutic relationship (B). These reactions usually do not become so intense in group therapy. For example, exceptionally dependent character types whose problems often spring from severe deprivation in childhood are protected from regressing to an attitude of complete helplessness (C). Persons who become immobilized by guilt when they receive the undivided attention of a therapist are relieved of this pressure by group membership (D). Another type of patient, whose problem is his inability to express hostile feelings toward authority, gains courage from the support of others (E).

Group therapy is helpful for a third category of patients because it deals effectively with certain kinds of defenses which result in avoidance of awareness of emotions. We refer first to persons with predominately psychosomatic complaints, who often learn in the group that their feelings are connected with their symptoms (F). Individuals who deny feelings and maintain a psychologically naive attitude often find this position difficult to sustain. The same is true of those who attempt to describe all experience in intellectual terms. Many such patients are able to benefit from brief individual therapy after an initial group experience.

Being faced with reality is particularly important for a final group of patients. Prominent among them are "acting-out characters" who constantly become involved in personal crises while denying their own involvement (G). This distortion is often clearly understood and challenged by other group members. On the other hand, psychotic patients who have partially reorganized their defensive structure seem to benefit from the opportunity to reestablish relationships with others in a protected yet realistic situation. This is also true of some patients who have worked through problems in individual interviews but who need the experience of applying their new insight in a supervised situation.

(A) A 26-year-old single male theological student came to the clinic complaining of inability to develop a satisfactory social life. He told us that he had been raised by elderly, non-English-speaking parents who were apprehensive about his joining his peers in normal group pursuits. We felt that he needed the social experience offered by a therapeutic group.

(B) A housewife, aged 32, complained of difficulty with her husband, mother-in-law and mother. She felt that they were all blaming her, yet seemed partially aware that her attitude was somewhat unrealistic. In her initial interview she quickly developed intense negative feelings toward the intake worker, reacting as if the worker were actually her mother-in-law. Because of this immediate transference reaction we felt that group therapy, with its tendency to reduce the intensity of such feelings, was the treatment of choice.

(C) A 34-year-old unemployed taxicab driver with a history of many job changes and periodic alcoholism came to the clinic

under pressure of his wife's threats to leave him. During his evaluation interview he presented himself as completely helpless and made repeated demands for a quick solution to his problems. Such marked dependent tendencies, we believed, would be discouraged by other group members who would focus his attention on reality problems.

(D) A 39-year-old housewife complained of headaches and depression. We learned that she was the oldest child of a large and impoverished family in which she had been prematurely forced into a parental role toward younger siblings because of her mother's chronic illness. It seemed apparent that her headaches were a response to the frustration of unsatisfied dependent needs. Moreover, her intense feelings of guilt prevented her from accepting such satisfactions when available. We recommended group therapy rather than individual because sharing the attention of the therapist would arouse less guilt. Another advantage was the opportunity afforded her to experience a more normal 'sibling-parent' relationship.

(E) A 25-year-old graduate student gave a history of failing in his work although he was of superior intelligence. In the initial interview some of his fear of competing with his father in a similar professional field became apparent. He was assigned to group therapy with the hope that support from other group members would help him to express more openly his hostile impulses toward authority, as represented by the group therapist.

(F) A 34-year-old housewife was referred by her physician because of episodes of shortness of breath for which no organic cause had been found. She described her home life as ideal and free of any emotional problems, but inadvertently revealed to the interviewer the existence of various areas of conflict. It was felt that group therapy would assist her to become more aware of emotional difficulties and their role in the causation of her symptoms.

(G) A 28-year-old divorced clerical worker with two young children seemed unable to organize her life or to avoid repeated crises. She lost jobs frequently, was deeply in debt, and entered into a series of short-lived and destructive sexual relationships. She presented herself as the victim of circumstances and in no way responsible for these developments. We assigned her to group therapy with the expectation that other group members would help her to realize her own involvement.

V. Just as there are certain categories of patients who seem particularly suited to group therapy, other individuals can be identified who are unable to tolerate the specific stresses created by the group process. First, there are patients with such intense social anxiety that they cannot even consider any kind of group participation (H). Moreover, in our particular groups the emotional tensions produced by the material discussed are such that patients with an imminent or active psychotic process are unable to carry the additional burden without further disintegration (I).

There are other individuals whose defenses, while identical with those of patients who respond favorably, are more rigidly maintained. For example, some persons with exclusively psychosomatic symptoms are threatened by even mild probing (J); also some extremely deprived patients are intolerably frustrated by failing to obtain the exclusive attention of the therapist. We are often unable to differentiate such pa-

tients at the time of their application. We frequently assign equivocal cases to groups for a therapeutic trial. For them, individual therapy on a once-a-week basis is ineffective in any case, and occasionally they surprise us by making effective use of the group process.

(H) A 23-year-old single woman applied for help with the problem of inability to become independent of her parents. She revealed that in three years of successful work in a large office she had been unable to form any social relationships because of awkwardness and uneasiness. Her previous difficulty in communication had been so marked and her anxiety in the initial interview was so intense that we felt participation in any group would be impossible for her. Individual treatment was recommended.

(I) A 30-year-old housewife and mother of three children was referred to the clinic because of numerous vague physical symptoms. She was assigned to group therapy, but it was soon apparent that an underlying psychotic process had been overlooked. She monopolized the group with a disorganized account of intimate sexual experiences. She was unable to tolerate the anxiety created and left the meeting in tears. In retrospect, the degree of her disorganization made her unsuitable for placement in a group.

(J) A 42-year-old, thrice-divorced beauty operator complained at the time of application of dissatisfaction with her job and fear of another failure in marriage. She realized that the men to whom she was attracted all displayed similar unsuitable qualities. She told of a markedly deprived childhood with the loss of both parents very early, of subsequent multiple foster-home placements, and of adolescent delinquency. In the group she monopolized the first hour with a tearful recital of her long, sad history. Her attempt to obtain justification for her actions and the sympathy of the therapist was compulsively repeated in subsequent sessions. She ignored the group's attempts to interpret her more basic feelings of loneliness and deprivation. Inevitably, frustration and subsequent interruption of therapy followed.

VI. Although the needs and defenses of the individual are considered first, we have found it equally necessary to evaluate certain factors arising from the requirements of the group itself in developing our criteria. The interaction of persons new and strange to each other results in the formation of a new type of social unit. Society offers no comparable experience. It is our impression that this unique social and psychological organization has certain needs which must be met by its members if it is to achieve its purpose.

An effective group must include some individuals who have an awareness of their anxiety and an ability to express it through a discussion of conflictual material. They stimulate the groups consideration of emotional problems (K). There also must be patients with a relatively high degree of perception and of sensitivity to the psychological problems and maneuvers of others. They are able to make interpretations which might be unacceptable if they came from the therapist (L). We believe it to be important also that there exist among group members a variety of social experiences, defensive structures and presenting problems. This provides an opportunity for contrast, comparison and self-evaluation.

Occasionally we may assign patients to a therapeutic group who could equally well be offered individual therapy, because of their catalytic effect upon the group.

(K) A 33-year-old divorced mother of two children complained of depression, irritability and frightening thoughts. In the initial interview she was able to reveal with considerable verbal facility both her anxiety and some genuine self-awareness, particularly of her competitive impulses and feelings of inadequacy. Because of these qualities we felt that she not only would herself benefit from group therapy but also would motivate other group members to examine their own relationships and feelings.

(L) A 28-year-old unemployed man gave as his reason for applying for treatment an inability to make a satisfactory job adjustment because of his resentment of all authority. When interviewed, he demonstrated the nature of his difficulty by being quite openly sarcastic but at the same time displaying considerable discomfort. He became less defensive when this was called to his attention. He also showed a good ability to size up other people. It was our feeling that in a group he could come to see more clearly the results of his behavior. Furthermore, because of his directness and his facility in the evaluation of others he would be able to make interpretations which the other members could accept.

VII. In the same way that persons with the characteristics mentioned above have proved indispensable for group progress, there are others whose behavior inhibits it. If they appear too deviant from the group norm, they should be excluded—even though they might gain personally from the group experience—to avoid a possible disruption of the group. Thus certain patients use incessant irrelevant and uninsightful talk as a defensive device. They monopolize group time and energy in this way, preventing constructive exploration of their own or others' problems (M). Others persist in attempts to engage the therapist in competition or to obtain his exclusive attention, ignoring the needs and rights of the rest of the group. In these circumstances the frustration of other group members often causes intolerable antagonism and guilt, which results either in isolation of the offender or in flights from the group.

The anxiety of another type of patient leads him to make a defensive attack upon other group members, the therapist, the therapeutic method or even the basic concept of treatment. Such intense attacks, occurring as they usually do in the opening sessions, destroy the confidence of other group members in the enterprise upon which they are embarking (N). Other patients have a self-destructive urge to reveal socially unacceptable symptoms in their initial contacts with the group (O). This means that patients must be excluded who are frankly delusional, who openly display bizarre ideation, or who would be indiscreet in discussing deviant sexual behavior. The above manifestations of pathology are very frightening to the majority of our group members.

We prefer to exclude patients who display tendencies toward overt suicidal, homicidal or infanticidal acts. Our groups are unable to deal with such traumatic material yet are prevented by its emergence from dealing with other less dramatic but nevertheless important problems.

(M) A 40-year-old housewife was referred with symptoms of severe headaches and phobias. In the initial interview she could only complain that numerous doctors had been of no help to her, that her husband was unsympathetic and ungrateful, and that no one understood her. She felt poorly repaid for her self-sacrificing life. At the intake conference, the group opinion was

that she would masochistically monopolize group sessions and thus inhibit more constructive discussion.

(N) A 36-year-old cab-driver complained that his wife was not sufficiently responsive to him and that he could not communicate with her. During his first interview he attacked the worker by questioning the latter's professional qualifications and theoretical orientation. He bragged of his own knowledge of "psychology" and demonstrated this by presenting a glib intellectual formulation of his problems. We felt that this was a patient who would be likely to disrupt an initial group session with this hyperaggressive behavior. He was therefore considered unsuitable for our therapeutic groups.

(O) A 28-year-old unemployed single man at first complained of depression and irritability. Even before effective rapport had been established, he blandly told of repeated episodes of exhibitionism and of his florid fantasy life. It appeared that he might well be as uncontrolled in his communications if assigned to group therapy. We have summarized the essential points of parts IV through VII in Plate 3.

PLATE 3

Summary of indications and contraindications for group therapy

PATIENT NEEDS

Our therapeutic groups are *indicated* for patients:

Aided by group support to express hostility to authority-figures.

Needing supportive social experience.

Whose emotional unawareness is reduced by group interaction.

Aided by group's pointing out and interpreting acting-out.

Made too anxious by one-to-one therapeutic relationship.

Needing to participate, even though non-verbally.

Needing protection from too intense transference feelings.

Benefiting from group protection against regressive trends.

Reacting with extreme guilt to individual attention.

Needing protected, though realistic, interpersonal experience.

Our therapeutic groups are *contraindicated* for patients:

Chronically experiencing intolerable frustration in sharing a therapist.

For whom material discussed could accelerate psychotic processes.

Unable to consider participation in groups because of intense anxiety thus aroused.

GROUP NEEDS

Our therapeutic groups are *strengthened* by patients:

With awareness of anxiety and ability to verbalize.

With perception of others' problems and defensive maneuvers.

With a variety of defensive structures, social experiences, and presenting problems.

Our therapeutic groups are *weakened* by patients:

Appearing so deviant as to be disintegrative to the group.

Whose exaggerated defensive reactions disrupt essential group exploration.

Whose anxiety is manifested by intense attacks in opening sessions.

Whose anxiety leads to destructive self-revelation in opening sessions.

Likely to perform overt suicidal, homicidal or infanticidal acts.

DISCUSSION

It should be re-emphasized that the foregoing considerations have been developed within a specific clinical setting with its own characteristic structure, function and limitations. Because of this it is recognized that conclusions drawn from this experience need not have universal validity. We hope, however, that therapists in somewhat similar situations may be able to use these criteria or to modify them to suit their particular needs. We are convinced that among the applicants to a general mental hygiene clinic some will be unsuitable for any type of out-patient therapy while others will be specifically amenable to the group approach.

A question may be raised as to the difficulty of predicting the complex types of behavior which have been described above, on the basis of a limited evaluation period. It has been our impression that, given a skilled interviewer who has had experience as a group therapist, sufficient data may be accumulated in an initial interview to permit a reasonably accurate estimate of how the applicant will react to the group meetings. Our interviewers make such judgments on the basis of information about how the patient has related to his immediate environment, both past and present, as well as his behavior in the interview and his response to tentative suggestions or interpretations made with the specific purpose of testing his defensive structure. Often, information from collateral sources (family members, referring agencies, etc.) can add to the total picture. At times we may place the applicant under emotional stress to determine his characteristic ways of reacting or his ability to respond in a constructive manner. In borderline cases, psychological testing may provide additional clues. All the information available is evaluated at an intake conference, the participants in which are for the most part themselves active in both group and individual therapy. This tends to eliminate any undue positive or negative bias of the individual interviewer.

Despite all these measures, it is at times unclear whether or not a given patient can make use of our therapeutic groups. Usually there are both positive and negative indications and some balance must be struck. As previously noted, in such equivocal cases, especially where the patient seems clearly unsuitable for individual therapy of relatively limited intensity and duration, we will often assign him to a group for a therapeutic trial.

We have not attempted to cover completely the question of balancing various types of patients for optimum group functioning, although we believe that this matter is of as great importance as that of the initial selection. Nor have we considered in this paper the effect upon selection of the anxieties and therapeutic skills of the group leader. It goes without saying that a skilled and experienced therapist can deal adequately with potentially more difficult group constellations.

Increasingly, community mental hygiene clinics are finding it difficult to offer individual psychotherapy to the ever-growing numbers of applicants for psychiatric treatment. Since we feel that group psychotherapy is the treatment of choice for a large proportion of these individuals, we believe it essential that there be continued study of the group process and the elaboration and perfection of criteria for its use.

SUMMARY

In this paper the hypothesis is advanced that certain types of out-patients are most successfully treated by group psychotherapy. The authors speak from a background of seven years of cumulative experience in an out-patient mental hygiene clinic. They discuss the structure within which they operate and its influence on the type of group psychotherapy offered. A standard method of classification of the therapeutic group is suggested. Dynamic considerations which contribute to patients' ability to utilize the group approach as well as personality characteristics which appear to contraindicate group therapy are discussed. Finally, the needs of the group itself as a special therapeutic medium are explored for their effect on the selection of patients.

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ESTHER KOVENOCK

Therapeutic use of the discussion process among residents in a home for the aged

The residents of the Milwaukee Home for Aged Jews[1] have had an opportunity to learn and discuss what transpired at Wisconsin's first Governor's Conference on an Aging Population.[2] This paper is concerned with the philosophy which underlay this experience, the method of presentation, the response of the residents and the project which grew out of this effort.

The professional staff saw the sharing of the conference proceedings with the residents as potentially valuable in several ways. Offering this material to the residents said: We regard you as people of worth and of a capacity to understand what is being thought and said about you. Because we are convinced of this, we will invest time and effort in presenting it in such a way that it will have meaning for you. We want your response as we do this, not only to test whether we are reaching you but also to get your reaction to the content. What you think about the ideas expressed is important both to us who try to serve you and to yourselves. We need your comments to validate our knowledge and to increase it. You can use your reactions to understand yourselves better, and therefore to live more comfortably and acceptingly with yourselves and your life situation. Where acceptance is not possible, perhaps together we may find better solutions.

If we could make this experience meaningful to the residents, it would reassure them that they could still participate in directing their own lives. People who live

This is an account of a project undertaken by Mrs. Kovenock while she was serving as director of social services at the Milwaukee Home for Aged Jews.

[1] The average age of the home's 105 residents is 80.

[2] The conference was held in Madison June 6–8, 1956.

in a home for the aged need this reassurance perhaps even more than other old people. This is true because in exchange for security and services they have given up some freedom, even where the needs of the residents are the paramount concern of the management. Inevitably there is conflict between the welfare of the group and the inclinations of the individual. It shows itself in such everyday matters as how long he uses the phone and what time he takes a bath. To run a home with reasonable efficiency and economy requires conformity to rules. Limitations in facilities and services bring other encroachments on individual freedom and invasions of privacy. For example, a resident may have to share a room. He takes his turn to see the doctor or the chiropodist. All of this heightens the feeling older people have that, with their dependence on others, they are lesser people. The feeling of rejection and failure which coming into the home symbolizes in the individual case also contributes to the sense of loss of status and worth. To counteract these factors we need to marshal all the resources we can find or create to strengthen the ego and enrich the life of the resident.

To carry out our purposes the social worker met with the board of the Residents Club before the Conference on an Aging Population and presented the material from the advance brochure. She discussed with them the reasons for the conference, what the conference proposed to do, for whom it was intended and whom it would feature. Among the concerns expressed by the residents in this discussion was that such a conference ought to be planned for the aging themselves as well as for those who serve older people. The suggestion came from one of them that such a conference should explore means to provide housing with services needed by older people, which would be administered without impairing the independence of the individual. They were agreed that the next Residents Club meeting should be devoted to hearing a report from the professional staff who were attending the conference.

We of the staff who presented the proceedings were the occupational therapist and the social worker, each using material related to her respective field. Since the level of acculturation to American life is relatively low among our residents, we used very simple English and relied upon illustrative material to interpret ideas and scientific principles. This did not lead us to eliminate material from our report on the basis that they were incapable of understanding. Rather, it challenged us to think deeply enough about what had been said to illuminate it from the life experiences of our listeners. As we succeeded in communicating, and sensed the intensity of their interest, we offered more of the content. With their approval and sustained interest the material was presented in three sessions of one and a half hours each, the comments and discussion dispersed throughout the presentation.

We reported in detail the speech given by Leo Simmons, Yale University professor of sociology. They responded with nods of agreement to his concepton of the basic wishes of aging people in all times and places. They commented on what he called the lessons he had learned from thirty years' study of aging, showing gratification that he understood how they felt and that he was so concerned about getting support from others to create the "brave new climate in which to grow old."

What we gave them from the paper by Ruth Cavan, associate professor of sociology at Rockford College, on the "Changing Position of the Aged in Our Society," struck a responsive chord. There were tears in

the eyes of several as they heard what was said about the emotional damage resulting from the death of a mate, adjustment being made more difficult by the insecurities which beset them, and particularly by the gap between them and their children, which deprived them of solace. They had some emotional release from expressing their sense of loss and rejection as the factors were enumerated which led to the gulf between the generations. They were comforted by having the universality of these feelings underlined. It was recognized by some that differences between parents and children were brought about by both, and that there was something they could do to minimize those differences.

They were cognizant of the problems for the aging brought about by American cultural values which are attuned to the future and to prizing the "attractive package." These points had been made by Dr. Jack Weinberg of Michael Reese Hospital, Chicago, whose topic was "A Psychiatrist Looks at Aging." From this we developed the theme that older people can be beautiful with the light and character that emanates from within, reflecting their attitudes toward others and their peace with themselves.

Dr. Weinberg's statement that "changes which make us dependent upon others hit our inner selves and make us resent the people upon whom we depend" was used to help them gain insight into their own feelings toward the staff. Many were critical of themselves, and especially of others among them, for the expression of those negative feelings. One of them, recognizing that residents sometimes made the work of the staff unnecessarily difficult, nevertheless felt that it was the privilege of the aging person to have someone on whom he could release his negative feelings. The staff people who led this discussion agreed, and tried to allay the feelings of guilt that some residents had about their part in this.

The occupational therapist applied to the practice within our home the information given by Dr. Frederic Swartz, member of the committee on geriatrics of the American Medical Association, and Dr. Alfred C. Kraft of Allegheny County Institutions, Pittsburgh, who spoke on rehabilitating the aged. This was an excellent opportunity to explain that handicapped people are best helped by enabling them to use all of their capacity for function. In this process, residents who observe or are themselves affected often think that nurses and therapists are hard and unfeeling, even cruel. The occupational therapist pointed out that making a wheelchair patient try to walk or a severely arthritic person try to feed himself was done to preserve and strengthen capacity, and thus help him to live more satisfyingly. Having the goal of rehabilitation in itself brings stimulation, a sense of the worthwhileness of living for the older person, and emphasizes independence. Effort is an expression of the will to live. For some residents this clarified experiences about which they had had resentment. But the staff was aware that we had made only a small beginning, and that continuous interpretation of our practices and the rationale for them was necessary.

The conference workshop on the "Team Approach to the Care of the Aging" was presented by enumerating all the possible services that an aging person might need. This was used to delineate the function of the personnel within our home. The director of nurses was brought into this discussion to help clarify the function of the nursing department. From this came a lively exchange between nurse and residents about accepting the need for tak-

ing medication for chronic conditions. The very venting of resentments about the burden of illness and weakness was therapeutic in this setting. Again the point was made that the staff can take the emotional outbursts of those who are angry with themselves and others for their handicaps—this time by the head of the nursing staff speaking for those who are the most frequent butt of these explosions. This acceptance of the negative feelings of residents as natural, and the expression of them as therapeutic, not only reassured them, but also created an atmosphere in which there was freedom to speak frankly. This led to a much greater feeling of ease between the staff and the residents who participated.

Important in the lives of our residents are the many volunteers who come here regularly to make the sheltered workshop more efficient, to run the beauty shop, to serve afternoon tea, to assist with the recreational program. As we talked about them and their role in our home, we raised the question whether some of the residents might themselves serve as volunteers to help those less able. This discussion has already led to the formation of two new committees of residents—one to mend clothes for those unable to do so, the other to be on call to help feed severely handicapped infirmary patients.

We used the conference material to interpret senility, emphasizing prevention and rehabilitation. Our purpose was to allay their fears for themselves and to help them accept the senile in our home. We did this with great care, aware that the subject was fraught with danger of heightening fears and revulsion. We were rewarded with the demonstration of some measure of our success. Some of our residents are now willing to assist the occupational therapist with group activites with the senile.

The value of this sharing experience is patent to us who planned and carried out this project. We saw it in the faces and words of our residents as we did it. They were comforted, reassured, encouraged to find new strengths within themselves. Books from the library about the mature years were circulated among those residents able to use them, and they began to bring to the attention of the professional staff articles on the subject that they saw in the press. This experience led to the development of an ongoing study and discussion group on aging. Excerpts or digests of books and articles were used to stimulate thinking and talking about their feelings about themselves and how others saw them.

We of the staff who participated gained in the empathy we experienced, in ideas for new ways to involve the residents in activities and in service which will bring greater morale and understanding between residents and staff. They voiced their approval by the quality of their participation.

SAMUEL D. SHRUT, PH.D.

Attitudes toward old age and death

It was the aim of this study to investigate differences in attitude toward aging on the part of older persons. As an index to this, attitude toward death was chosen, on the assumption that attitude toward death is a reflection of attitude toward living.

It was hypothesized that those subjects living under conditions approximating previous mode of independent residence in the community would reflect a less apprehensive attitude toward death, and generally be better adjusted to the life about them. Consequently, attitude toward death was compared with self-appraisal of health, adjustment in the institutional setting, and claimed participation in activities.

This study compared attitude toward death in ambulatory, currently unmarried, white females in two kinds of institutional living arrangements. Thirty persons residing in the apartment dwellings of the Home for Aged and Infirm Hebrews of New York were compared with a similar population from the same institution's central residential facility (Central House) in which the supervision and regulations are more traditionally institutional. The basic difference in the two modes of residence is that the apartment residents live much like other older people in the community, whereas those in the mass-housing or institutional setting (Central House) are more dependent upon the institutional organization, *per se*.

In each case, the research population consisted of volunteers obtained by means of random selection from a stratified sample, after consultation with the medical and social service departments of the institution. Subjects were well motivated to participate in the study, which was presented to them as having potentially beneficial consequences in possibly affecting housing arrangements for older people. Also, re-

Dr. Shrut presented this paper August 31, 1956 at the American Psychological Association convention in Chicago. He wishes to express his gratitude to Drs. Alvin I. Goldfarb, Carl H. Hamburg, Robert M. Eichler and Robert Kahn for their friendly advice and invaluable comments on his paper.

spondents were assured that they would remain anonymous.

The experimental design of the study consisted of comparing the two groups by means of a psychological test battery of instruments which, except for the Thematic Apperception Test, were especially devised, along with their respective rating scales, by this investigator. The instruments, in order of their standardized presentation, were as follows: questionnaire on self-appraisal of health, questionnaire for adjustment in the home, sentence-completion test, Thematic Apperception Test and questionnaire on claimed participation in activities.

Some brief statements about the various instruments in the battery are in order.

The health questionnaire was designed to elicit information on past and current medical history for the self-rating of health, on the basis of 5 categories ranging from "excellent" to "very poor."

The questionnaire on adjustment consisted of 17 detailed questions relating to food, supervision, rules and general interpersonal relationships of the resident in the institution.

The questionnaire on claimed participation in activities consisted of a series of detailed questions of possible activities involving physical and social pursuits in which the aged respondent may claim to take part.

A sentence-completion test and 10 TAT cards were also utilized.

Specific rating scales were devised for each of these instruments, each based on a 5-point range. Ratings were made by various categories of judges (a physician, 3 psychologists, at least 3 social workers), who rated protocols blind and made pertinent judgments of subjects, who were represented by code number to assure anonymity. These ratings were then averaged for the various groups of judges and comparisons were made. However, only the averaged ratings of the 3 psychologists-judges were employed in evaluating attitude toward death.

Death, whether considered traumatic, or tragic, or "a state of bliss," or a return to Mother Earth, or in terms of the organism's contest between the will to live and the desire to return to the inorganic state, poses a severe problem for most, if not all, human beings. Human response to death has run the whole gamut of emotional possibilities from stalwart indifference to severe and painful apprehension. There is the bracing statement in Shakespeare's *King Henry IV:* "By my troth, I care not. A man can die but once; we owe God a death . . . and let it go which way it will, he that dies this year is quit for the next." [1] Then, on the other hand, Gilbert, suggesting an apparent universality of the fear of death, takes pains to stress the importance of working with the aged to help ". . . prepare the aged person for death, which is inevitable and not too far away, in such a manner as to eliminate fear and help him to achieve serenity and happiness in his remaining years." [2]

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[1] Part 2, Act III, Scene ii.

[2] J. G. Gilbert, *Understanding Old Age,* 401. While it may be said that religion also aims to help people face death, it thus exerts an influence on how a person views life. G. Stanley Hall contends: "The most essential claim of Christianity is to have obviated the fear of death and made the king of terrors into a good friend, if not a boon companion, by this most masterly of all psychotherapies." G. Stanley Hall, "A Study of Fears," *American Journal of Psychology,* 8 (1896), 472.

The Hebrew religion is comparable to the various denominations of Christianity from the standpoint of its basic morality and religious orientation, and any sociologic and psychologic observations are applicable to the subjects of this research. S. S. Cohen, *Judaism, A Way of Life,* and K. Kohler, *The Ethical Basis of Judaism.*

Perhaps from the time when man first saw the lifeless form of his companion or enemy he has quite understandably begun to reflect upon death and what, if anything, "happens afterwards," and how this new lifeless state might be related to or concern him. While in the history of literature and mythology there is an abundance of writing, both in prose and poetry, on death, its sorrows and the happy or unhapply life beyond, there is a comparative lack of scientific writing on this subject. This is quite understandable because of its inaccessibility to scientific investigation in spite of its rich speculative possibilities.[3]

As one peruses the wealth of poetic and prosaic utterances that human beings have devoted to the subject of death, dying and fear of death, one is led to consider the variety of meanings that these words have assumed for different people and different ages. Considering this, it may be useful for the present research to distinguish at least three different concepts of death. The following brief distinctions concerning death concepts may be sufficient.

1. DEATH AS A TOOL

From a psychological orientation, death may be considered a tool with which to attempt to derive certain goals and satisfactions from the present environment. The concept of death as a tool in the psychological economy of the human being is, for example, much more ancient than is the history of suicide. While perhaps only so considered tangentially at times by the layman, death as a tool has increasingly been the subject of scientific inquiry, especially in recent years.

2. DEATH AS PASSAGE

By this expression, reference is made to the circumstance that death not only terminates but also initiates a new phase, transcending life, only to lead to a further state of being. The manner in which the death-initiated new "life" or new state of being is considered is dependent upon the prevalent belief systems entertained by different cultural groups. Death as passage between modes of being or "different worlds," according to the particular belief system, may be represented anywhere in the cultural spectrum from the gruesome to the glorious, or from calm anticipation to tormenting apprehension. Clearly, the particular version of the concept of death as passage directly affects the emotional tone in which death as a biological end is anticipated.

3. DEATH AS AN END

In this manner death is conceived of in strictly biological terms as a terminal ("the eternal void") event in the life span of the organisms. This, as a matter of fact, is singled out by Webster[4] as "the cessation of all vital functions without capability of resuscitation, whether in animals or plants."

Death as an end, it may be added, can never occur as an event to be actually experienced by the organism. As the Stoics held, no human being can ever encounter death, since where one is the other has already departed. As a result, death as an end is an event known to occur to us only by inference from generalizations established with respect to others.

While it is held that the particular beliefs that are entertained about death are

[3] Except for the biological definition of death, there have been comparatively few scientific investigations of the varying meanings and functions of death concepts and attitudes.

[4] *Webster's New International Dictionary*, second edition, unabridged.

reflected in the variations of responses from old people, it is the view of this investigator that the institutional mode of living itself modifies or affects significantly particular death attitudes. It is this hypothesis that will be examined by means of studying aged persons with comparable belief systems, as exemplified by the two groups of the present research population.

In general, the literature reflected that fear of death is universal and that any fear is essentially fear of death. Furthermore, the attitude toward death may be said to cover the spectrum from a seemingly preoccupying phobic reaction to one of complete indifference, with denial figuring prominently in the latter attitude.

Attitude toward death was specifically studied by means of clinical impressions of responses from the sentence-completion test and Thematic Apperception Test, along with judgments from the other protocols as well. Here it will be recalled that the other questionnaires (health, adjustment, claimed participation in activities) guided the interviews towards eliciting information in the areas suggested by the titles of the respective questionnaires.

Along with the specific rating scales devised for each of the instruments in the battery, there was an additional "summarizing" scale. The summary scoring of subject's attitude toward death, while not in itself a test, enabled the judges (in this case, psychologists) to combine ratings from all the instruments in the battery. While the various instruments attempted to focus on particular aspects of the respondent's behavior and outlook, ratings on the summary scoring were considered most reflective of attitude toward death because of the comprehensive data on which such ratings were made. For example, a subject's response on the health questionnaire may not have influenced the scoring on that instrument markedly. Or, the subject may have been relatively unproductive on the sentence-completion test, or may have blocked on card 15 ("death card") of the TAT, or may have indicated an indifferent attitude on the adjustment or claimed participation questionnaires, all of which findings are in themselves significant. However, they are not nearly so meaningful as when they are all taken in totality and the responses are seen to dovetail and interrelate, as reflected on the summary scoring.

Table I cites the mean ratings of three psychologists on several instruments employed to elicit attitude toward death for subjects of Central House and of the apartment residence.

On the sentence-completion test, the Central House group was judged to give responses more concerned with fear of death, while subjects of the apartment residence revealed an attitude in the direction of equanimity or indifference with regard to death.

The TAT indicated that both subject groups entertained at least mild apprehension with regard to death. While only a slight statistical difference was shown in favor of the apartment residents, a qualitative difference was reflected in that subjects of the apartment residence revealed greater productivity by averaging roughly an additional half-page (double-spaced) more than that obtained in the case of Central House subjects.

Apartment residents obtained higher ratings on the summary scoring, thus being judged significantly less preoccupied with fear or apprehension of death.

Fisher's "t"-test to evaluate mean difference of rated responses between the two groups revealed a difference significant at the 5% level.

The results indicated that subjects residing in the environment approximating

TABLE I

*Judges' mean ratings * on several instruments employed to elicit attitude toward death for subjects of Central House and of apartment residence*

INSTRUMENT	MEAN RATINGS ON 5-POINT SCALE		
	Central House residents	*Apartment residents*	*"t"*
Sentence-completion test	2.9	3.2	1.3
Thematic apperception test	2.8	2.9	0.59
Summary scoring of subject's attitude toward death	2.9	3.2	2.2**

* The 5-point scale, based on specific criteria, has the following range: (1) marked dread or preoccupation with death, (2) evident anxiety, (3) mild anxiety, (4) attitude of equanimity or indifference, and (5) philosophic acceptance.

** Significant at 5% level and beyond.

their pre-institutional home or domestic environment (apartment residence) revealed less fear of death. There is the consequent implication that subjects of apartment residence enjoy better mental health and are more concerned with planning for continued living than appears to hold for subjects of the traditional institutional facility (Central House).

The findings on the health questionnaire are shown on Table II.

Table II revealed that Central House

TABLE II

*Mean of self-ratings * on health for 30 persons from Central House and 30 persons from apartment residence, as compared with ratings by staff physician*

CENTRAL HOUSE RESIDENTS' SELF-RATINGS *	M.D.'S RATING	APARTMENT RESIDENTS' SELF-RATINGS *	M.D.'S RATING
Mean rating 4.3	3.4	3.9	3.3

* Scale points, based on specific criteria, range as follows: (1) very poor, (2) poor, (3) fair, (4) good, and (5) excellent.

TABLE III

*Mean ratings * on adjustment questionnaire for subjects of Central House and of apartment residence, as rated by social workers and psychologists*

RATERS	RESIDENTS OF		"t"
	Central House (institutional type)	*Apartment residence*	
Social workers	4.4	4.4	0
Psychologists	3.8	3.8	0

* The 5-point scale, based on specific criteria, has the following range: (1) very much dissatisfied, (2) dissatisfied, (3) indifferent, (4) satisfied, and (5) very pleased.

subjects' self-ratings of health were not only higher than the physician's ratings of their health, but also exceed similar ratings by subjects of the apartment residence. This marked over-estimation of good health suggests that compensatory mechanisms were operating more prominently with subjects of Central House.

Table III shows the respective mean ratings of social workers and psychologists for the adjustment questionnaire.

In the study of Central House and apartment residents, the judges found no differences in ratings of the two research populations. However, the ratings of the two groups by social workers were consistently higher than ratings by the phychologist-judges. The psychologists' ratings suggested that the respondents seemed nearly satisfied with their adjustment in the institutional setting, while social workers' ratings indicated that subjects in both groups were quite pleased with their institutional residency. There is the strong suggestion that a "halo effect" was revealed in the ratings of the social workers. This may be accountable in large measure to the tendency on the part of social workers to view ambulatory and active older people in a manner somewhat different from psychologists, whose less optimistic judgments are arrived at by the additional means of projective tests.

Fisher's "t" disclosed no difference in ratings of responses between the two subject groups.

Table IV indicated mean ratings on the questionnaire for claimed participation in activities for the two subject groups, as scored by teams of social workers and psychologists.

It was revealed that social workers rated Central House subjects as being slightly more active than the group from the apartment residence. Yet psychologists' ratings indicated that apartment residents were somewhat more active than the Central House group. Here again there is the likelihood of factors operating in a "halo effect" similar to those with the adjustment questionnaire.

The difference revealed with use of Fisher's "t" test was found to be not significant.

TABLE IV

*Mean ratings * on questionnaire for claimed participation in activities for subjects of Central House and of apartment residence, as rated by social workers and psychologists*

RATERS	RESIDENTS OF		"t"
	Central House (institutional type)	*Apartment residence*	
Social workers	3.6	3.3	—
Psychologists	3.7	3.8	.7

* Scale points, based on specific criteria, range as follows: (1) markedly disinterested, (2) indifferent, (3) mildly participating, (4) active, and (5) very active.

Also, the additional hypotheses concerning relationships between attitude toward death and self-appraisal of health, adjustment in the institutional setting, and between attitude toward death and claimed participation in activities were not found to be supported statistically to a significant degree.

CONCLUSIONS

Attitude toward death was evaluated by means of a psychological test battery on two equatable groups of 30 ambulatory aged, currently unmarried, white, female persons living under the two already specified modes of institutional residency.

The findings from this study yield the following conclusions:

1. Subjects residing under conditions approximating their previous environment of living independently (apartment residence) show less fear of, or preoccupation with, death than do those persons in an environment grossly dissimilar to what they were once used to. Consequently, there may be a basis for the belief that subjects of the apartment residence enjoy better mental health and are more concerned with planning for continued living than would hold true for subjects of the traditional institutional residence (Central House). This would serve to sustain the hypothesis.

2. Compensatory mechanisms, especially with regard to overcoming anxiety in the health area, were found to operate more prominently with subjects (institutional type) who indicated a less realistic estimate of their health than appeared to hold for the group from the apartment residence.

3. No clear-cut conclusions were suggested by the findings as to adjustment and claimed participation in activities for the two research groups.

4. On the basis of observed behavior and test performance, respondents from the more permissive apartment setting evidenced greater social alertness and greater productivity, and were more responsive, less suspicious and generally more cooperative than subjects from Central House.

5. The additional hypotheses with re-

gard to relationships between attitude toward death and self-evaluation of health, adjustment in the institutional setting, and claimed participation in activities were not confirmed by the statistical findings in this study.

6. While impressions from the various instruments of the psychological test battery were also taken into consideration, the sentence-completion test and the Thematic Apperception Test appeared to be relatively more productive in this study in facilitating psychological judgments of attitude toward death.

7. Both groups of subjects reveal at least mild anxiety with regard to thoughts of death.

Various research recommendations of a contiguous and ancillary nature present themselves for further investigation in the field of gerontology. There is a deeply-felt need for incisive and fruitful contributions to general knowledge about aged persons, and more specifically with regard to the effects of institutional residency, with its implications for planning with, and for, the aged person.

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MORTON J. ARONSON, M.D.

Emotional aspects of nursing the cancer patient

Psychiatrists, perhaps more than most physicians, appreciate the tremendous significance of the nurse in the emotional life of the patient. Our subject involves that area of organic disease in which it is difficult to imagine another as fraught with emotional involvement. The paralyzing fear of cancer, the adult's bogey-man, in patients and in ourselves, who in our mind's eye are possible future patients, presents a singular challenge. But before discussing those emotional problems particular to the patient with cancer it is worthwhile for us first to view some of the characteristics of the nurse-patient psychological unit and thus provide a broad backdrop against which to view specific cancer problems.

The nurse, whether she wants it or not, stands in the same unique relationship to her patient that the mother does to her child. The gentle, kind, beautiful figure in white who ministers to the helpless is the traditional popular stereotype of the nurse and this is the exact image that the child maintains of the idealized mother. To the sick adult, the nurse with her concern about food and pills, elimination and baths recalls the same role mother fulfilled. She even threatens to report bad behavior to the doctor as mother threatened to tell father.

Now the central fact is that patients, in response to the emotional stress of illness, adopt in varying degree child-like behavior in relation to the nurse-mother (1). The patient, powerless to gratify his own needs and dependent on another, reverts to the techniques he used in childhood in his dependent relationship with his mother, much as a beaten army falls back to a previously fortified position. These childhood dependency techniques and the con-

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flicts that surrounded them now burst forth, colored by the adult personality structure and influenced by the behavior of the nurse. Thus he may attempt to curry favor by ingratiation or demand it with the angry impatience so typical of children. He may exaggerate his discomfort to incur solicitude, or even be seductive. When the demands for tender loving care are frustrated, the inevitable anger may erupt in hostile outbursts or critical attacks on the nurse, or be expressed in self-damaging defiance by refusal to eat or take medicine, or be projected onto the nurse in the form of paranoid accusations or delusions, or be turned violently against the self in the form of a dangerous depression. Or, in the form of jealousy, anger may be diverted onto other patients who are rivals for the nurse's attention just as brothers and sisters were rivals for mother's love. These behavior patterns are, of course, everyday occurrences to nurses. It is an unusually mature individual who does not demonstrate, to some degree, one or another of these patterns in the course of a major illness. The important thing to bear in mind is that such behavior is meaningful and purposeful. It is the perennial cry of the sick for succor!

We have then a sketch of the patient's emotional orientation to the nurse. What of the nurse in this relationship? That she has the capacity and motivation to accept a maternal role is suggested by her very choice of occupation, a healthy acknowledgement of femininity in a world where so many women in other fields are struggling to deny their femininity and compete with men. But how successful the individual nurse is in drawing upon her maternal capacity to establish a giving, emotionally meaningful relationship with the patient is another matter. Of course, this varies from nurse to nurse and is determined by the whole complex of her personality structure, life situation and past experiences. One nurse may re-enact with her patient the loving care she gave her doll as a little girl when she behaved towards the doll as she wanted her mother to behave towards her. Another nurse, rejected by her mother in childhood and perhaps sadistic with her doll, may use the helpless patient as an object on whom to vent, however subtly, her smouldering resentment. Usually such a nurse will be completely unaware of what she is doing or why.

The two most damaging emotional reactions that a nurse may display with her patient are hostility and withdrawal. Her hostility may be simply in reaction to the patient's anger or critical, demanding behavior and is the result of her failure to understand what the patient is trying to say. Also, of course, she may take out on the patient the anger she couldn't express to the supervisor, physician, husband or children. Withdrawal, however, is far more common and often more damaging. This is the nurse who is busy and efficient but thinks of the patient as the pneumonia, the post-operative thyroid or the hypochondriac. She is too busy or disinclined to involve herself in the patient's emotional needs although these are often of far greater import than the physical needs. Sedation is her only answer to anxiety!

This withdrawal, or refusal to meet the patient on an emotional level, is a self-protective device. For in the patient's suffering one sees one's own possible future or that of a loved relative. To feel for the patient is, in a sense, to suffer with him and this is unpleasant and anxiety-provoking. Thus, in avoiding the patient as a person, one avoids one's own anxiety—much as the doctor in the autopsy room conceals his anxiety behind a highly intellectualized attitude of scientific curiosity.

But to the patient with his dependency

needs, emotional withdrawal is tantamount to rejection. The psychic pain that this gives rise to in an insecure patient may lead to a serious breakdown in his adaptive mechanisms. An example from recent experience involves a 72-year-old man, a resident in a home for the aged. A passive, clinging man, he suffers from bronchial asthma and a peptic ulcer. For several years he maintained a fairly comfortable adjustment with the help of a warm, maternal nurse who occasionally fed him his favorite food—warm milk—but did not permit him to manipulate her unduly. Then an intercurrent illness forced his transfer to an infirmary and another nurse. He made an early bid for the same relationship with the new nurse but she was "too busy to pamper him." He promptly developed an alarming exacerbation of asthmatic symptoms which made the nurse busier than ever with oxygen and hypodermics.

The emotional interactions between nurses and patients are of such moment that they can be ignored only at the patient's peril.

I have tried to highlight something of the psychology of the patient, of the nurse and of their interactions as a unit. These principles, of course, apply to the patient with cancer as well as to patients with other illnesses, but the special problems of the cancer patient and of the nurse who treats him are worthy of further consideration.

The idea of cancer in the public mind is intimately connected with the idea of premature, painful and lingering death. Often, also, it brings to mind horrendous fantasies of being devoured from within, being eaten alive. Alone among the animals in the knowledge of his own death, man has always stood in fear and awe of it. Human thought cannot truly conceive of death beyond the act of dying and wishful theories about a spiritual life hereafter. Biologically, the human machinery involved in appreciation of time stops with death, and since man can think only in terms of a present, a future and a past he cannot imagine death. Yet for centuries men have attempted to come to grips with their fear of death and this was a preoccupation of artists, philosophers and theologians. Until a few decades ago death was close to everyone, with more babies dying than surviving, with a considerably shorter life expectancy and with premature death from infectious disease a commonplace. But now medical science has made a long life expectancy everyone's birthright. Interest in dealing with the fear of death has declined with the decline of art and the well nigh universal concern with science and technology. Now man expects and is expected to die quietly in old age without fuss or undue expense or prolonged suffering for his family. The armbands of mourning are fast disappearing.

Thus our culture assists us in dealing with our fear of death by simply avoiding the subject. One of the most painful lessons of childhood, along with the realization that one is not omnipotent, is the awareness of one's own mortality. The sting is partially removed from this knowledge by the idea that death is a long way off, happening when one is very old. Since it is difficult for anyone to imagine himself as an old man, a comforting note of uncertainty is added to death. This rationalized avoidance of the knowledge of death is carried on into adult life to be only intermittently jarred by accidental death or death from heart attack. These deaths are mostly quick and unheralded. But cancer is quite another thing! For here is the popular idea, often unhappily true, of the death sentence—of certain death in the painfully immediate future. The recognition of this

knowledge as man's supreme fear lies behind the whole idea of capital punishment. The real punishment is the agony of waiting for the set date.

The intensity of the fear of death—or, more specifically, of immediately foreseeable death—varies from patient to patient. One may be more fully aware of it; another may be more successful in unconsciously hiding it from himself. Often other common fears associated with cancer consciously supersede the fear of death. The fear of being eaten up by cancer becomes the adult realization of a host of long-forgotten childhood fears. Psychoanalytic investigations have demonstrated that cannibalistic fantasies are common in early childhood (2). The child fantasies biting or eating the frustrating mother as an outlet for primitive aggression or as a means of making the parent part of himself, increasing his power by being the parent as well as himself. By the principle of an eye for an eye, a tooth for a tooth, the child fears that mother will punish him for such thoughts by eating him up. He works out these fears in fairy tales and nursery games in which the witch tries to eat the child but is finally thwarted.

In this same vein, cancer is often seen as a punishment, with the patient crying, "What did I do to deserve this?" The adult idea of divine punishment for sinful thought or deed is an extension of the feeling of guilt and a continuation into adult life of the magical thinking of children. For example, a child whose mother is ill may be overcome with remorse because he is convinced that mother's illness was caused by his angry thoughts about her.

The cancer patient may be harassed much more by the fear of mutilation or deformity than he is by the fear of death. This is by no means confined to cancer patients, as seen, for example, in wartime when soldiers commonly express their preference for death over the loss of a limb. Broadly speaking, such fears are related to unconscious masculine-feminine conflicts deriving from childhood fears of genital mutilations as punishment for forbidden sexual thoughts. Beyond this, mutilation fears in cancer patients, although partly rooted in reality, are also partly rooted in the emotional significance of the specific areas involved. For example, a colostomy may reawaken all the old fears of mother's rage at defecation in the pants instead of the pot. The loss of a breast in a lovely woman who admires these evidences of feminine beauty may provoke a mourning reaction as intense as if she had lost a loved relative.

In addition to the fears and anxieties that accompany cancer are the reactions of rage and depression with which many people react to the knowledge that they have cancer. Their bitter resentment at the cruel fate which deprives them of their work, their pleasures, their loved ones, certainly appears to be well justified by the reality. But there are those whose resentment, beneath the surface of awareness, is directed not at fate but at their own family and friends who will live on after they are dead.

The depressions with which many patients react to the knowledge that they are incurable are probably the most painful of the emotional reactions to cancer. The suffering of despair and hopelessness transcends any physical pain. Suicide is a not-infrequent sequela of such depressions, and Eissler[1] has theorized that these self-destructive acts are the culmination of a violent antipathy to a passive submission to death (3). Instead, the patient feels a triumph

[1] I am particularly indebted to Dr. Eissler's excellent work, *The Psychiatrist and the Dying Patient*, for many of those ideas discussed here that are pertinent to the psychology of the dying patient.

over nature by determining for himself the time and method of his exitus.

In recent years, medical and lay organizations have launched extensive campaigns of public education in an attempt to diminish widespread fears and misconceptions about cancer. By now, most people know that an appreciable percentage of patients can be cured if detected and treated early enough. The patient who, out of ignorance, ignored suggestive symptoms or delayed examination until too late has been helped by this campaign. But many, many more indulge in delay or belittling of symptoms not out of ignorance but out of fear. The magic thought is, "What I don't know won't hurt me." At a deeper unconscious level, delay may represent a seeking for suffering and death as atonement for real or fantasied transgressions.

An unfortunate by-product of the campaign for cancer education is the number of people who are cancer-phobic, imagine every twinge to be a growth and go from doctor to doctor for reassurance. Nurses and physicians are often irritated by these patients and dismiss them as neurotics or hypochondriacs, using the words to convey contempt. Actually, such physical preoccupation is frequently the only outward sign of a serious depression or an incipient psychosis.

The emotional problems confronting the nurse who takes care of the cancer patient depends, of course, upon the prognosis. The patient with a good prognosis, or even an uncertain one, will often respond to reassurance and realistic measures for rehabilitation from the nurse who can establish a warm and giving relationship. Those patients with special personality problems who do not respond will more often fall into the purview of the attending physician or psychiatrist to treat.

But the patient who is on the downhill course of palliative x-ray and drugs, intermittent or terminal hospitalization, presents a singular challenge to a nurse's emotional capacity to help. The burden is thrust upon her, for she is the only member of the medical team who is in any sustained contact with the patient. If she can conquer her inclination to withdraw into starchy but impersonal efficiency in the face of her own anxieties about death, and meet the patient on a human level, she may render an immeasurable service. For how can you measure the value of a relatively tranquil last few months of life as against an equal time of despair, depression and overwhelming anxiety? The nurse may ask why she should have to take up such an awesome burden. What of the patient's family? It is true that there are relatives who are capable of giving such help. But more often the relative is so emotionally involved with the patient and with his own grief that he cannot be of any real assistance. It is a curious fact of mental life that the impending death of a loved relative induces unconscious resentment toward him (4)—resentment for leaving the relative alone, for making him suffer the pain of mourning. The old resentments and memories of ill-treatment of the dying one come up to plague the relative with guilt. He is so immersed in his own inner struggle that he cannot relate to the patient in a helpful way and is often more of a problem to the nurse than the patient himself.

Fortunately there is a powerful psychological force that comes to the assistance of the nurse in her task with the dying. This is man's need to avoid the knowledge of his own death. This need is as old as man and has motivated all of the great philosophies and religions of the world. In the case of religion particularly, it has provided the strongest argument to believe. For if one can believe in a life hereafter,

whether it be in the Judeo-Christian heaven or in the happy hunting ground of the American Indian, one can convince oneself of immortality and deny the painful knowledge of death. The nationwide interest aroused by the Bridey Murphy story is understandable in this context. If one has lived before, then one may expect a future reincarnation on familiar earth instead of in a questionable heaven, and death is again defeated.

The techniques man uses for partial denial of the finality of death are varied and numerous. The political martyr may actively seek his execution in his conviction of the right and immortality of his cause. The artist finds his consolation in the belief that he will live on in his works, the scientist in his discoveries, the politician in history. The less distinguished man tells himself that he will continue in his children. Techniques for partial denial probably exist in every one. Many, however, are able to achieve complete denial of the knowledge of impending death in the face of incontrovertible evidence to the contrary. Consider the millions who went quietly to their death in the Nazi gas chambers, without resistance or revolt, in spite of the fact that they outnumbered their guards by hundreds to one. How fervently they must have wanted to believe that they were going to showers as they had been told.

Many nurses are familiar with cancer cases who were totally oblivious of their diagnosis in spite of obvious evidences of it. Such cases have been reported even among physicians.

I am indebted to one of my colleagues for his account to me of a case which demonstrates the ease with which one can help a suitable patient to achieve complete denial. A young lady came to his office in a panic, having just been informed by cancer experts that her pains were caused by an inoperable recurrence of her previously operated malignancy. He studied her x-rays, conducted an examination and then declared that the experts had been mistaken, that her symptoms were produced by arthritis. With the prescription of a regimen of treatment her panic dissolved and she spent the remaining months of her life in relative tranquility.

The decision to inform a hopeless cancer patient of his prognosis involves a heavy responsibility for the ensuing mental anguish. In my opinion, it is justifiable in only rare cases and should be avoided at all costs in patients with evidence of emotional instability.

Those patients who have completely denied the reality of their state and those who, although aware of it, are tranquil in their intense conviction of life after death present little emotional challenge to the nurse and she need be aware only of the injunction to do nothing to disturb their belief. But those who know that death is near because they have been told and those who, although not told, sense it or half know it, have vast needs for the understanding nurse. Even those who know are engaged in a see-saw inner struggle either to deny the reality of their approaching demise or to mitigate it with some concept of continuation after death. At the same time, they feel already set apart from the living and hover on the brink of despair. Despair and depression often supervene when the feeling of emotional isolation is conclusive. In the words of the poet, *"Sterben, ach sterben, muss ich allein"* (Die, oh die must I alone).

The nurse who can overcome her defensively mechanical approach to the dying patient and establish a warm emotional bond with him can now help in several ways. She can divert his attention to those of his interests and activities from which he can still obtain even a modicum of pleasure.

This does not mean that she uses these diversions as a way of changing the subject when the patient wants to talk to her of fears and death. For this is the time to listen sympathetically. To change the subject is to damage the emotional bond and to frustrate the patient's need to communicate and be understood. Through her conversations with him, she can learn the particular denial mechanisms he is utilizing and attempt to strengthen them. This strengthening is best accomplished with a minimum of words—a nod of agreement, a look of approval, a word of encouragement. An imaginative example of nonverbal strengthening of the patient's denial is in the case reported by Dr. Eissler in which he sent as a gift to his dying patient a subscription to the next season's concerts.

To those patients whose religious beliefs happily aid their need to deny death the clergyman can be of powerful assistance. But for a clergyman or nurse to proselytize a dying patient with religious or philosophic beliefs that are unacceptable to him is an unfair assault upon his dignity.

Finally, the nurse, unencumbered by the inner turmoil of the relatives, can show the patient, quietly and simply, her own sorrow, sympathy and pity. To the patient, these feelings of the nurse will cement the emotional bond that banishes aloneness and despair. Though he dies, he feels that he does not die alone, that a part of the nurse in a sense dies with him.

That the nurse should assist the patient in his denial of death and at the same time show her feelings at his approaching demise would seem to present a contradiction. But mental life is used to contradictions and the psychology of approaching death is characterized by them.

If the nurse be successful in her arduous emotional tasks with the dying, she fulfills to the utmost the ideals of her profession.

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Discipline

Its psychological and educational aspects

The director of the National Education Association's research division sums up the matter of discipline in these words: "Any assumption that most of today's children and youth are going to the dogs is a serious mistake" (1). This conclusion by Dr. Lambert is based on the responses to a questionnaire mailed by the NEA to a stratified sampling of classroom teachers, in which teacher opinion on the topic of discipline was asked. But much that is psychological, scientific, objective and technical in the area of discipline certainly needs expression, analysis, integration and ultimately implementation.

We know that in dealing with the administration of pupil personnel boards of education have the authority, either expressed or implied, to make and enforce any rule or regulation governing the conduct of pupils which is not unreasonable (2). It should be pointed out also that the authority of the school board extends to the pupil while off the school grounds if the act in question is such as to affect directly the discipline and good order of the school. It is well established that a board of education may discipline a pupil to the point of suspension or expulsion for disobedience of reasonable rules and regulations.

But parents, adults everywhere, and even teachers and school administrators are now deeply concerned over the kind of generation of children our schools are producing. Pronouncements in the press, in magazines, in books, and by parents themselves are often strongly critical of the schools and

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their effect on modern young people. The great confusion existing in the minds of parents and critics alike is owing in part to the change in the very nature of discipline itself. Because the so-called rod is ceasing to be the symbol of authority, and punishment is no longer the basis or impetus of school-boy effort, many people assume that discipline is disappearing.

A school of psychologists believes that perhaps America needs more than anything else at this time a generation of parents who accept as fact that their most important business in the world is the raising of children with proper and appropriate discipline. Our life today is far more complex, more demanding and more mobile than ever before, and parents often unwittingly rush their children into the obligations and doings that are inappropriate for them, simply to satisfy the whim and wish of the parents themselves. This too causes lack of discipline and lack of control in the pupils later in life.

Let us examine the area, problems, factors and ramifications of the field of discipline.

What is discipline? Educationally and psychologically, Smith's (3) definition is rather appropriate here, since its application is direct in most of our democratic classrooms: "School discipline is merely social control within the school group; it includes all the forces that mold attitudes and inspire conduct of pupils. Its essence is that subtle thing called school spirit. Thus in every phase of school work, the problem of discipline or social control must enter as part of the educative program, not incidentally."

In part, earlier concepts of discipline aimed to teach conformity and obedience. A pupil who questioned the word of a teacher was regarded as an upstart who deserved immediate and harsh punishment. The teacher's word was law, and failure to conform was punished by use of the hickory stick.

Both the method and the aim of discipline in today's school are different from those of former years. Today the aim is to secure good order and socially oriented self-direction. Order which stems from purposeful activity will not always be "pin-drop" silence, but it will persist without adult control. When given an opportunity, children continually surprise adults with their ability to be intelligently self-directive.

Let us examine the matter objectively and in psychological terms. One important aspect of discipline in the schools today is that punishment is largely directed toward the symptoms of misbehavior instead of being useful as a means of getting at the causes. The present view in psychological thinking leans in the direction of mental hygiene, *i.e.,* that causes must be determined before an attack on symptoms can be very successful. Authoritarian discipline often gets the desired result of conformity, but in far too many cases the tension takes some other form of expression. A teacher may get silence in the classroom upon demand, but the suppressed tension of the students finds vent in varied ways, *e.g.,* in writing on the hallway walls or in defacing the desks.

Psychologists feel that before an individual pupil's behavior is condemned harshly the causative factors in the social climate and the standards of the group should be analyzed. Behavior patterns are acquired during the total learning situation and consequently an individual's conduct cannot be judged apart from his social environment. Discipline, instruction and environmental factors are interactive; in this, educators are in agreement with psychologists. If the child is to acquire rational behavior,

he must have, as in other types of learning, the satisfaction of right responses and the related annoyance of incorrect responses. The type of activities from which a child derives his satisfactions certainly is an important consideration in guiding his behavior. The child who finds his greatest satisfaction from self-centered activities displays a lack of social maturity.

Misbehavior requires treatment and control no less than physical illness. However, treatment that breaks down self-confidence in a child and makes him overly fearful of rebuke can seriously retard his educational and emotional growth. Disciplining by parents or teachers that creates constant fears and anxiety will inhibit children by stifling their natural tendencies to explore and to experiment. Certainly punishment at times is warranted, but if punishment is inflicted it should have a corrective value as well as provide the child with a sense of having learned something that will guide him in the future. Punishment should not be inflicted for its own sake, nor merely as a quick emotional flare-up in response to a particular act of bad conduct.

Also, acquiring proper patterns of behavior involves self-activity on the part of the learner. For children to be able to grow in self-discipline, they must have ample opportunity to secure this growth. Where children are working cooperatively under the guidance of a teacher to achieve goals they have planned to work towards, there is no thought of conduct except to determine the best method of achieving the group's objectives. Discipline here is inseparable from teaching. Wholesome growth in discipline takes place as children gradually assume more and more responsibility (4).

The teacher may well be concerned with the sum total of temperament, outlook and habitual choice which involves the personality of the child. Children should be given the tools of analysis and should be given the opportunity to pass judgment on conduct just as they are given a basis for passing judgment on the merit of a piece of literature. Growth in proper behavior must be based upon the insights and understandings of how individuals may become better judges of good and evil (5).

If it is to be effective, discipline must be predicated on certain basic rules of conduct. If our future society is to be strong and sound mentally, emotionally, physically and educationally, parents and teachers would do well to acquire fundamental knowledge and sound habits in the training of children. Regular hours of rest and sleep, coupled with wholesome food, are requirements not only of the home but of the school in its indoctrination of children. Parents must be consistent in their handling of children, loving them yet being firm, and must give of their time to explain the responsibilities of daily living. Discipline is also based on proper home environment, a home in which religion is made the cornerstone, not merely given lip service. This must, of course, include parents who truly love each other and live together in mutual respect. Discipline of children also requires a father who feels his responsibility for participating in the training of the child, in all possible ways.

In diagnosing children's behavior the teacher must come to recognize the part that emotional factors play in determining human conduct. Many of the important decisions made by our pupils, particularly by the more immature among them, are largely on an emotional basis. Fundamentally, the function of education is to lead the child toward greater mental maturity and thereby assist him in making more of

his decisions on a rational basis. Yet one who takes a realistic view of human behavior cannot fail to recognize the critical impact of the emotions upon conduct.

The child needs practice in learning to behave appropriately in various situations. It is no more reasonable to assume that errors in behavior may be eliminated by verbal instruction alone than it is to expect that errors in grammar may be eradicated so easily. Only as the child is presented with numerous opportunities for correct action, together with an understanding of its real meaning, does he learn to behave in a better manner. He then must practice continuously so that acceptable behavior becomes more or less automatic and habitual, even involuntary.

Another important psychological principle is this: Only when the individual understands the implications of his acts do they become significant and aid in his character development. When the teacher acts merely as a censor for outward mannerisms, she thwarts the child's growth in accepting moral responsibility for his actions. The teacher should play the role of stimulator to right behavior, rather than critic. Certainly learning to behave properly is among the most complex of all learnings. It is achieved only by constant effort. Children need guidance, not dictation, in establishing habits of good conduct.

Many factors and conditions influence child behavior. In order to understand and direct a child's behavior in an intelligent manner, the teacher should recognize that individual behavior is in part the result of many forces in the community. Some of these forces are economic; others derive from the standards of conduct of other children and adults. Particularly significant in the thinking of the child and his overt behavior are the standards of values held by the children of the group with whom he associates. Where a community sets wealth as a standard of personal value, a child's acceptance by various social levels or units may be mainly (and unfortunately) on an economic basis. Even if he has a sound personality, possesses qualities of leadership and is able to gain admittance into the so-called exclusive circles, he may still be confused in his thinking and even be handicapped in his activities. The point we are making is, nevertheless, that the teacher has the responsibility of assisting pupils in the developing of a sound set of values.

Studies of children enrolled in schools reveal that too many are handicapped by serious defects or illnesses. Many more have minor defects. It is to be remembered that problems of behavior may often be traced directly to the child's physical handicaps. Even feelings of physical inadequacy result in social maladjustment and acts of misbehavior. This is particularly true if the handicap is serious enough to prevent the child from taking part in gym work or sports.

Many factors account for restlessness in children. Malnutrition, poor vision and defective hearing contribute to poor achievement and the child then is irritated with the school situation. The teacher should not be too quick to punish, and should be able to recognize signs of malnutrition and of possible mental and physical fatigue.

Just as the teacher should understand child behavior, she should recognize the basic needs of her pupils. Every child needs to have feelings of security, a sense of belonging and a growing realization of adequacy or success. If he does not satisfy these needs in some part at least, his need for satisfaction may manifest itself in negative behavior, at school and in the home. Emotional blocks may even develop in a

school situation in which the child is subjected to strongly rigid requirements of conduct.

Essentially, the so-called "problem child" may often be the product of heredity rather than environment. New findings in human genetics may in time nullify the prevailing tendency to blame all defects in personality on a child's early environment and conditioning. According to some teachers and other adults who work with delinquent and seriously undisciplined children, too heavy a burden of blame and responsibility is often placed on the parents of children who were supposedly "just born that way." There is mounting evidence that heredity produces degrees of susceptibility or resistance to innumerable traits and characteristics which often are regarded as purely environmental. These children who are delinquent may have been born with tendencies which incline them much more than other children to abnormal behavior or functioning. In fact, psychological thinking would prevail upon teachers, parents and adults to avoid calling everything "environmental" or "psychosomatic" or "conditioned." Needless to say, then, the greatest and most immediate hope of the field of education should be in reducing human defectiveness in whatever area and also in improving environmental factors.

The seriousness of behavior difficulties is often determined by the mental maturity of the individual. A child of low intelligence is often susceptible to the suggestions of other persons and might find himself in a behavior situation without discriminating as to the seriousness of the difficulty or its implications. But many problems requiring discipline often arise among children of high intelligence, too. If the school situation fails to present a challenge for the bright child to exercise his mental abilities, boredom and restlessness may cause him to misbehave.

Parents can learn a lot about dealing with their children's behavior by becoming familiar with disciplinary lessons that every teacher is expected to know. The object of discipline is to help an individual to do what is expected of him; and if a child is to do what is expected of him, he must first be helped to understand real goals and limitations. Children need the security that comes from feeling there is a guide, a protective authority that will watch over them. Basic to good discipline also is the function of helping the child develop a feeling of personal worth. The good teacher and the good parent should provide the kind of discipline all children need; that includes, among other things, giving the child a limited area in which to experiment and make mistakes, helping him understand his mistakes, and showing how the problems of living call for certain kinds of behavior.

Let us not overlook this fact, namely, that a child's behavior is greatly influenced by his home environment. The standards of conduct of his parents are usually reflected in the child's acceptance or rejection of their behavior patterns. Discord in the family resulting from parental differences over the severity or the methods of punishment often results in confused and inconsistent child behavior. Bickering and arguments in the home are conducive to emotional disturbances in the child. The presence in the home of a more talented or a more gifted brother or sister, or a favorite child, may cause deep resentments on the part of the child less fortunate or less favored. The child of an immigrant or foreign-born family which may have been subjected even inadvertently to acts of discrimination in the community may be un-

able to make a satisfactory adjustment to school life. The rather important point here is that, even if it may be necessary at times to correct a pupil's actions immediately, the teacher has the responsibility to search for and, if possible, to find the causal factors of misbehavior.

Estes (6) states: "After punishment is administered the effect on the organism is to produce an inhibition of behavior." Although a teacher may prevent a pupil from sucking his thumb by shaming him, the teacher may not notice that the pupil's insecurity may now show itself in his withdrawal from the groups in which the teacher works. Repressions may serve the needs of teachers at times, but does not help the child to become more self-directing.

Study of the psychology of the school group reveals many factors contributing to anti-social or unsocial conduct of individual pupils. In an analysis of the structure of the school group, Sheviakov and Redl (7) suggest six factors which may cause undesirable individual conduct. The following is an adaptation of their viewpoint:

Dissatisfaction in the work process. The subject matter may be too easy to challenge the abilities of the students, thereby causing them to seek other outlets; or the subject matter may be too difficult and produce student indifference or irritation. Also, assignments may be poorly planned.

Emotional unrest in interpersonal relations. Tensions growing out of strong friendships or animosities among pupils may supersede work interests. Competing cliques may become emotional disturbances. Clashes of personality between pupils and teachers often result in serious maladjustment.

Disturbances in group climate. By the term "group climate" Sheviakov and Redl mean the basic feeling tone which underlies the life of a group, the sum total of everybody's emotions toward each other, toward work and toward the organization.

They give the following examples of different types of group climate:

Punitive climate: One in which pupils are accepted or rejected on the basis of the teacher's behavior code.

Emotional blackmail climate: In this situation the children develop a strong emotional dependence upon the teacher and there is strong rivalry between the children who conform and those who are not close to the teacher.

Hostile competition climate: Everybody is whipped into competition with everybody else. The result is extreme uncooperativeness among members of the group.

Group pride climate: In its extreme form, feelings of group vanity and conceit may result. The individual who does not meet all the requirements of group loyalty may be made an outcast subject to group persecution.

Mistakes in organization and group leadership. During the period of adolescence there is need for the gradual emancipation of the child from adult domination. Some of the features of the school organization which disregard this need of youth are too much autocratic pressure, too much organization, and group organization out of focus with the age, maturity, background and special needs of the group.

Emotional strain and sudden change. A member of a group may become unduly excited about examinations, athletic contests

or community events. Sudden changes in behavior requirements, techniques and leadership frequently result in emotional upsets of both individuals and group.

The composition of the group. Frictions and discipline problems may develop unless children are grouped on the basis of criteria relevant to group life.

Parents and teachers sometimes place too much faith in the rational process in trying to get across to children the importance of certain rules of behavior. There are times when the adults should simply say to children that a rule must be insisted upon only because the adult knows better what is good for the child. The democratic way is, of course, vital in working with children, but we must not make the mistake of thinking that children will follow rules and regulations just because they have been carefully explained and discussed. Discipline cannot be totally permissive; yet ruling children haphazardly through fear and punishment can be damaging. Within a framework of adult-set limitations and controls, the child must still have freedom to make mistakes and to experiment, for only in this way can he develop the inner controls necessary for self-discipline.

To be sure, the amount of freedom suitable for a child depends upon the child's age and maturity. The ideal situation in terms of discipline is one in which areas of freedom are inconsistently widened over the years. Also, an atmosphere of love and acceptance is the first essential for helping children grow in self-discipline. Along with conditions stimulating to free action, there is a need for careful organization of the child's life at school; as children grow and mature, they should take increasing responsibility for helping to establish their own limitation and rules. In many situations in a child's life, however, the teacher, the parent, the adult generally, must assume final responsibility; and in such situations, vagueness or confusion make for poor discipline.

We feel that all pupils should not be disciplined in the same manner. The shy pupil may well be treated kindly while the deliberately mischievous child may require more vigorous methods of control. There is certainly need at times for placing restraints upon the activities of individuals and groups of children but the manner in which the restraints are imposed is especially significant. There are a few basic considerations which teachers may find helpful in preventing individual violations of good behavior. Bernard (8) lists several of these, again keeping in mind that mental hygiene is the basis of good discipline.

Teachers must understand the nature of children. It should be remembered that growth takes place on uneven fronts; because pupils may have gained independence in one area does not necessarily mean that they can reasonably be expected to be independent in all activities. The degree of pupil control usually varies with the situation. It is natural for children to desire freedom of movement; to restrict this freedom unnecessarily or injudiciously is to ignore one of their innate drives. The teacher should recognize the individuality of each child. Every child is unique and the teacher should understand this just as she understands that every pupil's learning interest varies. All pupils cannot be forced into any one particular kind of mold, intellectually, academically, emotionally.

Strict domination should be avoided. While there must be order underlying productive work, the lock-step procedures all too often used in classrooms do not bring about con-

tinuously productive activity. Work done under compulsion develops a distaste in the pupil.

Discipline should be appropriate and consistent. Appropriate discipline takes into account the individual, the time, the total situation and the degree to which the behavior differs from the individual's typical responses. As to consistency, one should not overlook a given response at one time and deal with it decisively and abruptly at another time.

Shaming, sarcasm and ridicule should be avoided. Any procedures which belittle another person may tend either to undermine his own sense of worth or to stimulate resentments that are destructive to a cheerful classroom atmosphere. When sarcasm and ridicule are used, it is not likely that the child will get the security needed from the feeling of companionship with his teacher, his school and his fellow students. Any words or actions which undermine his feeling of personal worth must be strongly condemned from the standpoint of good discipline.

Pupils should be kept busy with interesting tasks. If the child is interested in his work there will be less need for imposed discipline. Busy and interested pupils have no time for acts that could keep them from reaching their objective.

A good adult example should be set. Much behavior is learned by direct imitation and much by unconscious imitation or suggestion. Pupils try to imitate their admired teachers. Especially in high school, boys and girls consciously aim to pattern their behavior after teachers whom they have selected as heroes. Because of this, a teacher's attitude toward aspects of discipline (lying, cheating, work habits, etc.) has direct influence on the conduct of his students. Not only the words he speaks but the attitudes he reveals may be taken as models by the pupils.

Friendliness, fair-mindedness and respect for others—or suspicion, jealousy and bigotry—are learned from one's intimates. This does not mean that a teacher has to be perfect. If a teacher cannot always be a sound example of self-discipline, he or she can at least make a consistent effort to grow better toward self-control.

Seek the cause of misbehavior. At times a student does something just because he can get away with it, but usually misbehavior is generated by some tension or deprivation felt by the child.

Have confidence in self and pupils. Autocratic procedures by the teacher are likely to grow out of personal feelings of insecurity. The teacher may demand strict conformity because of the fear that things will get out of hand; he must be confident that the pupils are capable of assuming responsibility. Children enjoy living up to expectations. If they know mature conduct is expected, they will strive for it; but if they know the teacher suspects them of incompetence, it will not likely hurt their feelings to show the teacher that he or she is right.

Use reasoning. Understanding is necessary to self-discipline. The teacher has the responsibility of explaining to erring students the reasons for rules and regulations in general and the reason for a specific requirement in a specific case. This reasoning should take place when the teacher is emotionally calm. If reasoning is attempted at a time of emotional stress, there is too great a likelihood that what is said will degener-

ate into wrangling, even nagging. Teachers should not expect youngsters, even of high school age, to understand their own motivation; it is therefore not very practical to try to reason with them by asking, "What makes you do this?" Too often, the pupil honestly does not know the answer to such a question. It is better psychology to try to have the pupil place himself in the situation of another. Try to get him to see how he would feel on the receiving-end of the very behavior in which he has been indulging.

Authority must be positive. In many schools pupils participate in the making of disciplinary policy and share in carrying out the policy. However, the teacher is accountable for classroom conduct. Specialization carries with it authority that can be and should be used constructively.

Provide for substitute behavior. Instead of forbidding the child to interrupt what another is presenting in class, the teacher may ask him to wait his own turn and then make some thought-out contribution (9). Instead of telling him only that he must study, the teacher should make an attempt to discover why he is not interested in the project and help him find some aspect of it that will challenge him. Providing substitute activities is not being educationally or psychologically "soft." Rather it is recognition of the fact that behavior is caused; that the ultimate aim of discipline is self-direction; that growth is an individual process; and that a mature individual must get along without constant supervision.

Discipline should be democratic. Democratic discipline has a triple advantage. It is in accord with the objectives and principles of our society, and thus provides preparation for more effective adulthood. It tends to capitalize on individual assets, and thus provides a means of stimulating growth toward independence and self-direction. And it lessens the chances of generating habits and tensions that are harmful to mental health.

Wholesome discipline can be developed when the teacher's direction is not only positive but also cooperative, fair, consistent and attentive to individual differences. Such discipline depends on teachers who have a thorough knowledge of growth principles in general and an appreciation of the specific causes of behavior in terms of the school and out-of-school backgrounds of individuals.

Too often discipline is thought of in the school only. Essentially, discipline must have its impetus and origin in the home. Only those children with parents or guardians who are themselves well disciplined may be expected to be soundly disciplined as individuals. No greater mistake can ever be made by parents than to attempt to discipline children by temper and by screaming at them, or by pushing children around in a bullying fashion. Parents actually set the example through their own personal conduct of the standards they profess to want for their children; there are too many parents who preach one thing and do another, however. Discipline of children requires parents who are honestly interested in their children's activities; who try to find out what the natural interests and activities of their children are; who encourage their children to discuss problems with them; and who try to help their children to find opportunities for development of those aptitudes and interests that the children too, at the time, feel to be important in their lives. Basically and fundamentally, disciplined parents will have disciplined children if they encourage their children

to accept responsibility and allow them to share consistently and intelligently in family planning within the family group.

Those of us concerned with the entire field of discipline and its psychological implications should realize that there are at least a number of aims of education that we should strive for in the foreseeable future. Not only psychologists but teachers working directly with pupils of all ages may well give much thought and planning to teaching children to be critical observers and listeners. Children should learn to live and work together harmoniously. They should be taught functioning skills in such academic subjects as reading, writing and arithmetic, to help decrease the possibility of delinquent action and behavior in later years. They should be taught how to seek facts and to find answers. They should understand human geography; they should develop a thorough understanding of the peoples and cultures of the world, however different and varied they may be from their own. Children should be taught to adjust to change without fear. They should learn to express themselves clearly in order to communicate with others. They should learn to respect leadership and learn to regard authority not with defiance but with sufficient respect for the experience, the training and the knowledge that proper leadership requires. They should be encouraged to meet their fullest potential; they should not just learn to read, for example, but learn to read as well as they are capable of reading. Finally, they should be taught by parents, teachers and other adults to develop a sense of responsibility to each other in their roles as citizens of the community.

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GORDON J. ALDRIDGE

The influence of Freud on social work

In a brief consideration of Freud and social work one faces the dilemma of selection; his influence has been pervasive and persuasive. Of the three basic social work processes—case work, group work and community organization—case work is the one which most directly sought and responded to psychoanalysis as a theoretical framework, a treatment system and an intellectual movement. Hence this paper, while attempting to reflect Freud's impact on a profession, will be specifically concerned with his influence on social case work.

Although professional social work is generally considered a twentieth century and primarily North American phenomenon, it loses perspective if seen outside the historical framework of social work and the social sciences on this continent and in Europe. Some form of meeting social and personal need has probably been with us as long as men have lived together in groups. From more or less well-intentioned efforts to temper human distress, social work has emerged as a professional activity through which communities seek to give help to those in need in a purposeful and enlightened way.

Until the last hundred years the church remained the chief source of this helping function, as reflected by the work of St. Vincent de Paul in the seventeenth century and of Frederick Ozanam in the nineteenth. The emphasis throughout was on a kind but somewhat repressive giving or withholding of help to the "worthy," and the help was largely confined to material goods.

The indiscriminate giving of alms seemed to increase rather than reduce the problems arising out of rapid industrial expansion. The Elizabethan Poor Laws had attempted to bring order out of the chaos of public relief, but it remained for the German community experiments of the eighteenth and nineteenth centuries to develop

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the beginnings of an organized system of private welfare. By 1869 this system had reached England and was incorporated in the Charity Organization Society. The way had been prepared by the work of such people as Thomas Chalmers and Octavia Hill, who began to call attention to the need for individualization in social problems. Octavia Hill (1), sometimes referred to as the first case worker, said: "Alleviation of distress may be systematically arranged by a society; but I am satisfied that without strong personal influence, no radical cure of those who have fallen low can be effected."

The Charity Organization Society, also established in the United States a few years later, was a crucial development in the history of social work. In addition to its functions of coordination and investigation, it helped to underline the growing concern with the theory and practice of personal service and responsibility. The case workers (or friendly visitors) spoke of personal influence rather than relationship, but they recognized that the feeling between the visitor and the person being helped was of some importance. This was also the period in which there was beginning recognition of the need for some formalization of knowledge and training, and some concern with the perplexing fact that different people behaved differently in similar situations.

With the turn into the twentieth century, social work moved into what has been termed the sociological stage. There was increasing concern with the kind of social order in which man lived and a growing conviction that man's life experience was environmentally determined. Hence, moderation of the environment was considered the answer to social difficulties: place the child, change the job, move the family, even break up the home. Classification was a major goal, and was applied to problems, causes and treatments. For a time there was a movement away from individualization, and persons in need of help were dealt with largely in terms of their category of distress. The plan for assistance was often one worked out by the worker, and the client was considered "uncooperative" if he did not follow it.

There were, too, certain strengths emerging from these experiences. The family was identified as the vital social unit. The importance of knowledge about people and their behavior was recognized. And, although the knowledge of dynamic psychology was limited, the existence of intrapsychic factors was recognized although their modification was thought to be best effected environmentally.

These early years of the twentieth century were marked also by important discoveries in the fields of medicine, psychology and sociology. Social work was beginning to move beyond the confines of the social agency and into working relationships with other disciplines, notably medicine and psychiatry.

The sociological and environmental approach was reflected at its best in Mary Richmond's definitive book, *Social Diagnosis* (2), the first systematic and scholarly written statement of the philosophy and techniques of social case work. She understood individual differences, although the understanding was sociologically rather than psychologically oriented. Her discussion of the offering of professional help to persons in need is still pointed. She spoke (3) of "processes which develop personality through adjustments consciously effected, individual by individual, between men and their social environment."

While the publication of *Social Diagnosis* in 1917 marked an important formulation of existing knowledge, World War I

provided a testing ground for new theories. Psychiatry and social work were both involved in the problems of adaptation to military life and, later, to postwar reactions. Social workers, already suspicious that environmental manipulation was not enough, grasped the opportunity of learning more about emotional factors in human behavior. By the 1920's the concept of the unconscious mind and its part in the motivation of behavior had enlarged the social worker's horizon to the extent that the client's continuing material needs were sometimes relegated to secondary concern.

The new psychology was not specifically Freudian. As Virginia Robinson (4) has stated, there was "indiscriminate interest in any new psychological theory on the part of case workers." From study of the emotional implications of other relationships, social workers concluded that the professional meeting of client and worker also must have considerable meaning. This was recognized in 1928 at the Milford Conference (5) when, in discussing "social case treatment," the group said: "The flesh and blood is in the dynamic relationship between the social case worker and the client . . . ; the interplay of personalities through which the individual is assisted to desire and achieve the fullest possible development of his personality."

Although Jessie Taft discussed the "transfer" in relationship several years earlier (6), it was not until the 1930's that psychoanalytic understanding of the significance and therapeutic use of relationship was given substantial attention by social workers.

Then came what has sometimes been termed the era of rampant Freudianism, or the psychiatric deluge. With growing acceptance and incorporation in its techniques of the dynamic teachings of Freud, psychiatry was going beyond the walls of the mental hospital into the community. It became more concerned with helping the person in his adjustment to life than with classifying his illness. Social workers, familiar with the frustrations of attempting to help persons with emotional problems, recognized that psychoanalysis offered a body of knowledge and a treatment system. They could readily identify with this new emphasis and for some the identification led to a diluted kind of psychoanalysis as case work procedure. Emphasis on the emotional content of what were loosely defined as social problems led to such a swing away from the sociological orientation that the environment was almost forgotten. Although the agencies continued to give material assistance, this was looked upon as an appendage rather than a positive part of the helping process. The practice of passive case work, in which the worker was merely a vessel or sponge for the cathartic flow from the client, flourished until it became evident that neither the new knowledge nor the expression of feeling from the client had much value unless the worker took an active or catalytic part.

The depression of the thirties arriving about this time had a profound effect, with its reminder that the environment is of great importance and that the "inner" and "outer" man is one indivisible man. Despite the handicap of heavy case loads, two basic facts became clear: man's feelings and behavior are influenced by his social surroundings and economic status and, equally, his feelings and his established patterns of behavior influence his choice of method for dealing with his social surroundings and economic status. Man, then, could have problems that are internal or external and would react to them intellectually, emotionally and physically, but neither his problems nor his reactions to them could be put into watertight com-

partments and labeled—his environment affects his feelings and his feelings affect his environment (7).

The years since 1940 are sometimes referred to as the generic stage because they represent not only the bringing together of knowledge gained from the biological and social sciences but also the bringing together of the common denominators of different areas of social work. There has been a tendency for greater objectivity in social case work practice, characterized by more selective use of Freudian theory and of concepts from allied disciplines, particularly cultural anthropology. While this has led to a lessening of intensity in Freudian discipleship, it has contributed to more appropriate and focused application of psychoanalytic principles. The case worker deals with problems of intrapsychic conflict, but by relating treatment constantly to the realities of day-to-day living. The therapeutic goal in social case work is twofold: to reduce pressures in the environment and to fortify the client to bear pressures. The general aim of treatment, then, is to reinforce the person's ability to find suitable solutions to his problems and to operate on a more mature and effective level. The case worker, aware of the interplay between social and personal factors affecting the individual, seeks an integrated approach to the problems of social adjustment. Diagnostically, he seeks to gain an estimate of the kind of personality structure, of the individual's current capacity to function and of the motivating forces in his behavior. These provide a basis for determining the kind of help that can be appropriately offered.

Perhaps the outstanding contribution to social work practice during the last 25 years has been the development of psychoanalytic principles as the theoretical base of the case work process. Some have rejected or sharply modified certain of these principles—for example, the functional approach within the University of Pennsylvania School of Social Work—but even here the Freudian formulation provided the basic structure. The content drawn from psychoanalytic theory which has been incorporated into generic social case work theory has, through time and experience, been adapted to meet the needs of persons served by social work agencies. Four broad contributions from Freudian theory have been suggested as being of primary importance (8).

First, the body of knowledge deriving from a dynamic approach to the development of personality, and particularly the importance of experiences in infancy and early childhood, has revolutionized social case work practice. The significance given interpersonal relationships as well as other social and environmental factors has served to alter the entire nature of the social case work function. In an intuitive way social work, with its stress on the importance of the family as a group, anticipated the importance of the psychoanalytic view in this area.

A second contribution identifies the helping person as a variable in the helping process. The acceptance of the necessity for continuing self-scrutiny on the part of the helping person is crucial in the development of the professional self.

A third, related to the second but qualitatively different, has to do with what happens between two persons when one is receiving and one is giving help. The importance of relationship was known to social workers before the advent of psychoanalysis, but this new knowledge permitted clearer understanding of its elements and greater ability in its controlled use. The relationship became recognized as the medium through which the client is enabled

to find new ways of considering and coping with his problems and himself. Within the case work relationship, understanding of the concepts of transference and resistance was fundamental. Psychoanalytic theory substantiated what social case workers had observed in practice, namely, that what happens between two persons in a helping relationship is appropriately different from what happens between two persons in other relationships.

A fourth contribution, basic to the previous three and the cornerstone of Freud's whole philosophic structure, is the concept of unconscious motivation. The new knowledge about the implications of the unconscious helped to give systematic meaning to social workers' earlier observations of unexplained and irrational behavior. They could see that they might need to help the client to identify previously unrecognized, and perhaps unacceptable, ideas and feelings. Although the case worker deals essentially with accessible memories and feelings, he is constantly concerned with derivatives of the unconscious.

Freud's detractors and dissidents have been many. However, in the field of social work, particularly social case work, it is difficult to identify a comparable influence. An enduring contribution has been the stimulation to question and to progress beyond existing knowledge, including that developed by Freud. Social work is considering critically and selectively contributions to its body of knowledge and methods from all disciplines, including psychoanalysis. At the same time, it has been building a body of knowledge and a methodology increasingly its own. Nonetheless, its indebtedness to this most provocative of thinkers and scientists cannot be minimized. In this, social work is not alone. As Dr. Paul Federn (9) puts it: "Freud's work was a contribution to the common task of all scientific professions which deal with the human mind and the human personality; it is dedicated to the whole of mankind."

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Book Reviews

MIGRATION AND MENTAL DISEASE

A Study of First Admissions to Hospitals for Mental Disease, New York 1939–1941

By Benjamin Malzberg and Everett S. Lee

New York, Social Science Research Council, 1956, 142 pp.

This monograph is statistically a very careful piece of work, and one feels that its conclusions are sound. The figures definitely show that the rates of admission during the years studied were much higher for migrants than for non-migrants. Depending upon the definition of migrant that was used, the differential varied from 100% to 300%. This increase in admission rate was defined for three groups of psychoses which were separately examined, namely, dementia praecox, manic depressive, and psychoses other than dementia praecox and manic depressive. The materials also made it possible to infer that the psychosis rate for those having cerebral arteriosclerosis and senile psychosis was also higher among the migrants than the native-born.

The second conclusion warranted by the study was that the rates of first admissions for the three groups of psychoses was definitely higher for recent migrants than for earlier migrants.

In assessing their findings the authors make the point that the New York statistics which they used may be to some extent atypical because the facilities in New York State allow for immediate admission whereas in other states from which the migrants came lack of facilities would keep them in the population for a longer period of time, so that their age on admission in those states would therefore be greater. Another point of caution is that there is a higher proportion of migrants living in urban areas than in rural areas, where the disturbed individual is easier to keep at home and indeed retains his usefulness in the community longer than he does in an urban setting.

A third point made by the authors—and one interesting to speculate about—is that perhaps the very factors which motivate an individual to migrate may also result in mental disease; or, put another way, the early stages of mental disease may be accompanied by migration.

A fourth reservation is this: the authors feel that the State of New York is atypical because it contains the City of New York, where assimilation may be very difficult. The reviewer is inclined to feel, however, that the melting pot that is New York City should present areas in which the migrant would find it easier to adjust than in many other parts of the United States because there he finds people from his own background and can thus make a more gradual transition—or, in fact, if he is motivated not to make a new adjustment, he can live to a great degree as he did in the "old country" from which he came. I would think, however, that an exception to this would be the southern Negro who goes to New York City and finds a culture very different from that from which he came.

The monograph is valuable because it seems to this reviewer to show in an accurate, statistical way that there is a relationship between social pressures and mental illness. As the authors suggest, much more work needs to be done to explore more in detail the effects of the vairables that go into the pressure factors that have been

studied. Especially engaging for study is the question of whether or not migration is an evidence of mental illness.—FRANK F. TALLMAN, M.D., University of California.

DISASTER, A PSYCHOLOGICAL ESSAY

By Martha Wolfenstein

Glencoe, Ill., Free Press, 1957, 231 pp.

Since the advent of nuclear weapons there has been a growing concern about the manner in which people react to disasters. In this essay, an attempt is made to correlate observed behavior in response to catastrophes with possible psychological mechanisms. Clues to the presence of these mechanisms are largely sought in the recorded remarks of survivors. Much of this clinical material is drawn from studies conducted under the auspices of the committee on disaster studies of the National Research Council during the last 10 years.

As a collection of tempting hypotheses this book is well worth reading. Largely analytical in their orientation, the interpretations of possible unconscious motivations cannot be regarded as particularly new, but such superficial documentation as was available gives the speculations a certain vitality and promise of validity. A strong plea is made for collection of much more clinical data which might tend to prove or disprove the theoretical formulations contained in the essay.

The significance of denying danger is presented as variable according to the phase of the disaster in which denial occurs. Volunteer workers in civil defense and other disaster relief organizations will not be reassured in their efforts by such a conclusion as that on page 8: "Thus, in relation to remote threats, we may say that those who are relatively free from inner strain will not be likely to worry about them, and such worry when it occurs will usually indicate some emotional disturbance."—CALVIN S. DRAYER, M.D., Philadelphia.

THE PSYCHOLOGY OF HUMAN DIFFERENCES

By Leona E. Tyler

New York, Appleton-Century-Crofts, 2nd edition, 1956, 562 pp.

Dr. Tyler's revised edition of *The Psychology of Human Differences* is again an excellent presentation of the subject. The author has wisely curtailed the chapters dealing with statistical methods and devoted more space to the problems germane and basic to the problem of appraising human differences.

The book is divided into four parts. Part 1 is devoted to a survey of the field of differential psychology; part 2 to varieties of individual differences; part 3 to group differences, and part 4 to a discussion of the factors effecting or producing these differences. Part 3, in addition to considering such topics as sex, age and class differences, has an excellent chapter on the mentally deficient and another on the unusually gifted.

Dr. Tyler's discussion of the various topics is both broad and comprehensive. The numerous studies that have appeared in the decade since publication of the first edition are carefully surveyed and judiciously selected. She presents both sides of the question, and it is an indication of her impartiality that it is not easy for the reader to surmise which points of view she may be favoring. At the same time, all data presented are critically appraised. The volume as a whole is of interest not only

to psychologists but to all persons concerned with the problem of human differences and their appraisal. An extensive and up-to-date bibliography adds much to the general usefulness of the book.—DAVID WECHSLER, PH.D., New York University—Bellevue Medical Center.

GROUP WORK IN THE PSYCHIATRIC SETTING

Harleigh B. Trecker, ed.

New York, William Morrow and Co., 1956, 224 pp.

This report presents all papers read at an institute conducted by the American Association of Group Workers along with a summary of the workshop sessions and general statement of group individual reaction. Forty-five group practitioners, faculty members and specialists in the field of mental health brought together their experiences and viewpoints to explore and elucidate the growing areas of group work in the psychiatric setting.

The report is of special significance since it represents one of the first collective attempts through an organized institute to define basic principles of group work with the mentally ill in a psychiatric setting. The difficulties inherent in such a task are apparent and might naturally color an attempt to evaluate the present accomplishments and prospectus for future gains. Participants can easily become so over-concerned with dynamics of the individual approach as to under-stress group goal-directed activity, the goal practicum of major importance. It is also quite natural to devote one's time to the task of trying to define the role of the group worker in relation to other disciplines in lieu of the less intriguing but nevertheless highly important demonstration of distinctive skills so clearly brought out in these discussions as inherent in the discipline of the social worker.

In recognition of the currently increasing need for help in the treatment of mental illness such explorations into the areas of group work are important *per se* and the practical application of such contributions as this assumes additional significance. While it appears that much of the material is too summarized to provide the detailed information needed—as, for example, Redl's chapter on treatment of children—the comprehensiveness of the text in exploring various viewpoints, generic and specific, in group work practice, concepts of the therapeutic environment, implications for professional education, evaluations and plans for the future make a most helpful contribution.

The selected bibliography related to social group work in psychiatric settings is unusually extensive and adds much to the practical application of the interesting and informative viewpoints and findings.—JOHN EISELE DAVIS, SC.D., Association for Physical and Mental Rehabilitation.

MENTAL HEALTH AND SPECIAL EDUCATION

Rev. William F. Jenks, C.S.S.R., ed.

Washington, D. C., Catholic University of America Press, 1957, 235 pp.

This volume is the report of a workshop on mental health and special education conducted June 15–26, 1956 at the Catholic University of America. The report is divided into two parts. Part I is devoted to a presentation of the formal papers on such topics as the child with cerebral palsy, the speech defective child, recent medical ad-

vances in mental retardation, the prevention and control of juvenile delinquency, and preventive measures in the field of mental health. Several other papers cover the role of the school, the teacher and the parent.

Undoubtedly it was the intent of the director of the workshop to present a broad overview of the field of special education. The parochial schools, in general, are just beginning to interest themselves in this field. Special education is comparatively expensive. Diagnostic studies, special equipment, smaller classes and skilled teachers are essential to success in this field of education. Until recently most of the Catholic school-age children in need of special education had to seek such in the public schools of the communities.

Unfortunately, most of the special lectures here reported cannot be considered very helpful to the classroom teacher; at best, they call attention to need and to techniques in diagnosis. It is true that Part II, Summaries of Seminar Proceedings, would indicate that opportunity for the teachers to come to grips with the classroom situation was provided for through small group discussions. The reviewer got the impression that these small group discussions were the most important activities of this workshop.—HENRY C. SCHUMACHER, M.D., U. S. Department of Health Education and Welfare, Atlanta.

GAMES FOR THE NOT SO YOUNG

By Syd Hedges

New York, Philosophical Library, 1957. 108 pp.

The purpose of this small but helpful book is to "lessen loneliness and to enhance good fellowship" for older adults. This objective is admirably served by a wide variety of games of all types.

Included in this collection are games that are fairly common in game encyclopedia, but others are novel and entertaining and will be of particular value to those working with older adults in clubs and groups. We know that older persons can enthusiastically enter into the spirit of fun and make the most of it and that recreation can be a therapeutic agent in lessening the effects of advancing years.

Mr. Hedges brings to this book an understanding of aging and the challenges it affords as well as the limitations it imposes. The games included here are geared to the interests and needs of the older population and in many instances call upon the older person's abilities and experience. They also enable him to gain personal satisfaction and a sense of achievement and accomplishment.

The English flavor of the assortment of games is reflected particularly in the second chapter on games for two players. A preponderance of games of "draught" calling for the use of a "draught board" are cited. These are not familiar to American audiences as such but are known in the U. S. as games of checkers. To the knowledge of the reviewer we do not have the variety of such games as are here enumerated. One incongruous section of the book—so far as American audiences of older persons today are concerned—is that dealing with an old-fashioned spelling bee. The words listed are so complex that I am sure the average college graduate would stumble over them.

On the whole this is a valuable collection for recreation personnel and in addition will provide many entertaining hours for those shut in for short and for long periods of time.—MILDRED K. LINZER, Massapequa (N. Y.) Senior Citizens.

VOCATIONAL COUNSELING WITH THE PHYSICALLY HANDICAPPED

By Lloyd H. Lofquist

New York, Appleton-Century-Crofts, 1957, 384 pp.

Dr. Lofquist states that this book was written to meet the need "for an analysis of information available on disabilities and medical conditions and an integration of this information with the principles and techniques of vocational counseling, placing particular emphasis on the applicability of such information and techniques to the work of the hospital and rehabilitation counselor." Dr. Lofquist has accomplished what he set out to do.

This small volume clearly spells out the basic philosophy, methods and techniques of vocational counseling in a hospital setting. Although the book grows out of a Veterans Administration hospital setting, the same basic principles of vocational counseling could be applied to any other rehabilitation setting. It is a comprehensive book that could be used either as a college textbook or as a very adequate working tool for a rehabilitation counselor or selective placement interviewer.

Dr. Lofquist includes in his book a complete treatment of the diabetic, the amputee, the heart patient, the hypertensive, the paraplegic, the cancer patient and the skin patient. He bases his selection of these disabilities on the fact that they have not been fully discussed in the literature on rehabilitation. He discusses sketchily blindness and visual disabilities, hearing disabilities, tuberculosis and psychiatric disabilities, justifying this action by stating they "have been fully discussed in literature with respect to rehabilitation." The consensus of those in the rehabilitation field might not agree with Dr. Lofquist on this point. However, it may be that his selection is influenced by the kinds of problems he has encountered in the Veterans Administration hospital. One would expect that the author, being a vocational counseling psychologist, would include the psychiatric disabilities as a major chapter. Certainly there is some question as to whether sufficient literature is available on the vocational counseling of patients with psychiatric disabilities.

Of particular interest are the illustrative case studies. Dr. Lofquist presents his case facts as "counseling developments" and then side by side discusses the "possible implications." This device very succinctly points up the kinds of questioning that go through the counselor's mind during the development of a case. This material should prove invaluable in the training and development of new counselors.

The case study material is practical and realistic in that Dr. Lofquist does not limit himself to successful case counseling studies. In too many books we are given only a superficial treatment of counseling and all examples used are generally dramatic successes. The inexperienced counselor coming into the field must realize very early in his career that all counseling will not be successful and that he must learn to expect failures. At the same time, however, he must also gain the ability of learning from his failures. For this reason, the case material is excellent and should really stimulate a counselor trainee in thinking through some of the basic problems he encounters.

Of particular interest, too, was the discussion on the relationship between clinical psychologists and vocational counseling psychologists. Dr. Lofquist sincerely tries to delineate the differences between these two specialized branches of psychology. It is his feeling that each has its place in the rehabilitation process and he likens the two

specialities to specialities in the field of medicine.

The book is based upon the teamwork approach in a hospital setting where all the disciplines are available for consultation and discussion. One can understand that members of a team operating under one roof can be more cohesive than members of a team scattered throughout the community. It is possible to eliminate poor communications and to educate the members of the various disciplines so that all are appreciative of the contributions each may make and all are working towards a common solution. This book does give one a feeling that what has been accomplished in this one hospital could be extended to many of our hospitals in communities throughout the United States.

If all major hospitals throughout the country had trained vocational rehabilitation counselors, the patient, his family and the community all would benefit.—JANET I. PINNER, New York State Department of Labor.

LEARNING TO LIVE AS A WIDOW

By Marion Langer

New York, Julian Messner, 1957, 255 pp.

Dr. Langer's book is directly addressed to widows; in fact, it tells of "your" emotions and suggests how "you" may cope with the many problems which beset you. Although this stylistic device may be slightly irritating to some readers, it does help one feel the common humanity beneath the anxieties that seem so special. The author cuts through the social myths about widowhood to the basic numbness, bewilderment, fear and pride, the strange guilt and resentments which all women experience in varying degrees, with varying emphases. The book is thoroughly non-technical, but clearly draws upon the insights of a trained psychologist.

The book begins with a description of "what happens to you"—a sympathetic presentation not only of painful grief but of the side emotions which are likely to cause worry because they seem inappropriate or "bad." It is helpful to realize that they are natural. Dr. Langer urges taking time to mourn. There is no cure but time for the pain of grief. Usually it is desirable to preserve the *status quo* of one's old life for a while, giving the shocked roots of one's emotional life time to send forth new shoots in their own way.

Later chapters take cognizance of the fact that the widow is faced with a variety of reality pressures from the beginning. She must handle money and often earn money. Her social life changes. Her children have suffered a blow as serious as her own and must be helped on *their* terms. Their callousness and brief storms of grief must be seen as childhood manifestations, not to be taken at face value but understood as important gropings toward acceptance of a new reality. (It is best to tell the truth, but patiently, a little at a time, repetitiously, in response to the child's questions.) And finally there is the new life to be planned for herself and her children; renewed interest in men, perhaps remarriage.

A useful appendix offers concrete information about the resources available for psychological and vocational counseling, legal advice, social security benefits, etc.

After recommending maintenance of the *status quo* if at all possible during the early months Dr. Langer points out the importance of taking stock of one's self—as a person in one's own right and as a member of society whose merits may not be immediately recognized by employers,

whose status as a single person makes continuance of a social life typically organized for twosomes practically as well as emotionally difficult. She does not blink the unpleasant realities of these situations. Many of them are exaggerated—in part created—by our own defensive attitudes, however. Refresher courses or training in a new vocational field often pay for themselves many times over, not only in money but in new satisfactions. Some of one's old friends drop away with the change in one's way of living, but new ones appear through one's work, through one's children, through many activities neglected during one's marriage.

Although a gradual growth into new vocational and social interests is usually desirable, the widow who has mistakenly plunged into the wrong work may still reconsider. Is it just that the daisies seem brighter in the next field? Are we blaming harsh realities for an inner unhappiness no external change can cure? Or could we reorganize our lives in a manner to lessen tensions with mother who has come to help out, to work at something we enjoy? Would our children perhaps be benefited by having a happier, stronger mother rather than a sacrificial drudge who cannot help a nagging solicitude because she has too far restricted her life to theirs?

Dr. Langer cites the experience of many widows encountered in her work as counselor. They never quite come alive in the book because only the fragment of their lives appropriate to the point under consideration is given. This reviewer feels that the reader would gain a richer, deeper sense of the problems of widowhood if some of the cases had been presented in greater detail. The complex interweaving of past and present, of the many different aspects of one's life, is largely lost in adherence to a topical outline. One identifies easily with the fragment, with a residual, "but things are not so simple." Although one cannot identify fully with all the details of another woman's life, reading about a real person makes the complexities of one's own life somehow more understandable.—RUTH L. MUNROE, New York City.

SCHOOL HEALTH AND HEALTH EDUCATION

By C. E. Turner, D.P.H.,
C. Morley Sellery, M.D.
and Sara Louise Smith, Ed.D.

St. Louis, C. V. Mosby Co., 1957, 466 pp.

This book, prepared for teachers and prospective teachers but useful for all persons concerned with school health programs, deals with school health education, school health services, and healthful school living. It reflects modern concepts of how schools can protect and improve health and contains references to numerous committee reports.

The 20 chapters are divided into two parts, the first presenting "The Basis for School Health and Health Education" and the second "School Health and Health Education in Action." The former gives historical information, definitions and objectives, and discusses school-community relationships. The latter describes the "school health team" and shows how its members function in carrying out various parts of the school program. A list of resources is included, as well as suggestions for evaluation of results.

The high professional standing of the authors, coupled with their actual experience in school health programs, helps to

make this a valuable and authoritative source of information and guidance.—CHARLES C. WILSON, M.D., Yale University Department of Public Health.

CULTURE, PSYCHIATRY AND HUMAN VALUES

By Marvin K. Opler

Springfield, Ill., Charles C Thomas, 1956, 242 pp.

Dr. Opler has utilized his anthropological background in this critical review of social psychiatry. He points out that the "effect of culture on personality and thus on mental illness and symptoms is recognized but methodological problems have not been totally considered." Scarcely any study of an epidemiological sort has combined these influences—physical, environmental and cultural. The factor that most epidemiological studies have ignored is the attitude towards illness which affects the incidence level in any society.

Dr. Opler's cross-cultural anthropological data, drawn from the work of anthropologists and psychiatrists, supports such conclusions as this (p. 50): "Thus, hypotheses which postulate that categories of deprivation (death, weaning or toilet training, job loss, etc.) are predisposing and relate to incidence of disorder are clinically assumptive and no amount of quantification, apart from distinctly known cases, can convince one that remote variables are not being manipulated."

He believes psychiatry has achieved its major success with a clinical study of individual patients and laboratory experiments, with the best potential area for therapeutic practice—management, education and prevention—being the epidemiological approach of field and experimental studies of disease processes in groups of people. However, the isolation or identification of characteristics associated with mental disorders does not provide sufficient understanding of the disease process. General interrelationships between culture and personalities need to be formulated, although psychiatrists usually are lax in this respect.

The cross-cultural data presented allow Opler to state (p. 59) that the "style of weaning or a mode of achieving spincter control, as isolated and independent features of a culture, will not predetermine adult personality configurations. Instead it is more likely the cultural attitudes towards infancy and childhood, its kinship setting, and the values of human individual worth will affect the infancy handling and disciplines, the parental behavior and the family functioning."

The advanced psychiatrists, he feels, have moved away from the Aristotelian approach which deems that behavior of all things is determined by their nature (and which might posit individual urges for freedom, creativity and spontaneity) to the Galilean which states that the behavior of all things is determined by the conditions under which it occurs. "It is classical psychiatry and prescientific anthropology which both spoke descriptively, and rarely analytically, of organic attributes, excluded environmental influence, denoted racial entities, delineated the 'unit psychosis,' described invariant typologies whether in illness or in culture, and failed to discover process or contextual referents anywhere. Freedom, creativity and spontaneity do not exist *sub specie aeternitatis* any more than does mankind. Culture, human values, and psychiatric resultants may be more closely linked in real cultural systems than the men of any one of them have ever dreamed." (pp. 62, 63.)

The "composite picture" which some psychiatrists have attempted to secure can be

obtained, according to Opler, only when culture, social group and personality are studied in actual relationship and when samples of well and ill are matched within a series that holds constant each factor in turn.

In discussing the Rorschach and thematic apperception tests, Opler raises the question in regard to highly acculturated situations whether reality testing and disintegration are distinctions fine enough to do more than separate the very well from the clearly ill regardless of cultural context or the sub-types of disease groupings. Even on the more solid grounds of symptomatology, he states that "there can be no doubt that psychopathology is culturally influenced." He then backs up his statement with a number of studies such as Stainbrook's Brazilian research, which shows that catatonia obviously operates differently if it emanates from different cultural backgrounds.

In relation to ecology, the author states that "the description or definition of urban ecological areas is a first step, not a last, in the study of the actual lives of people in modern, urban communities." Such gross statistical data on urban regions or areas of the city may describe the main contours and outward living conditions of such areas, but in order to accomplish a thorough understanding of how personalities in the culture continually operate the ecological approach must rid itself of a static quality, not merely in terms of human drift within its framework, and focus on processes.

The Nova Scotia study by Leighton and the Yorkville study in which Opler is a senior anthropologist are presented as research in which actual inspection by anthropological field methods preceded and guided survey tactics, thus carrying them beyond the usual rubrics of housing, income and educational level, or ethnic and religious labels, into the total texture of functioning social and cultural forms. Although the ecological survey is the first mapped assessment of an area, it cannot be assumed to touch the cultural and historical conditions under which a group of ethnic variables operate. The methods such as the Rorschach, the TAT, the Cornell Medical Index and others simply do not operate uniformly across cultural boundaries. But these methods may be useful in understanding differences provided cultural variables are understood.

In discussing the importance of cultural evaluation and psychiatric diagnosis and treatment, Aubrey Lewis is quoted as saying: "Consequently in studies that originate with the psychiatrist there is a strong bias. The psychiatrist, moreover, is so close to the problems of his patients (which are disclosed within the same culture, usually, as the doctor lives in) that he forgets that some of these problems might cease to be problems if the culture changed."

This reinforces the reviewer's observation of the common fallacy among social workers, psychiatrists and psychologists that the change has to be in the individual. This orientation toward changing the individual, along with the formerly believed innate source of interrelation conflict, ignores the fact that the individual may be ill or have symptoms as a result of a situation which, if corrected, would no longer result in that type of symptom etiology.

Opler states that therapy must deal with defensive mechanisms which individuals use to cope with inner conflicts and exceptional life strains through careful diagnoses based on clinical, psychodynamic evidence and observation. The problem for social psychology is to trace how a kind of rudimentary defense mechanism characteristi-

cally originates in the setting of normative cultural behavior and how typically in given conflicts and strained circumstances it becomes intensified. Preventive psychiatry therefore cannot omit the so-called normal functioning of a society.

On reading this work, which basically is on the emerging interdisciplinary science of social psychiatry, one acquires an optimistic feeling towards the future of psychiatry and anthropology as a means of providing the basis for prevention or treatment of those symptoms which develop into mental health problems. It is the researchers among the psychiatrists that are far ahead of the practitioners and it is this type of research that may eventually penetrate the practice of psychiatry.

Psychology also suffers from lack of cross-cultural comparisons, and it is hoped that such works as Opler's will enlighten this field which has contact with so many developing students. Both clinical psychology and psychiatry, as currently practiced by many, do not recognize the effect of culture on the conscious and unconscious.

To read Opler's book requires an extensive knowledge of psychiatric language and literature, for his references and quotations are not extracted in detail or explained sufficiently. Primarily a review of the literature with a consensus of the various findings, it is a fine job of compilation but it is somewhat poorly organized and difficult to read. One idea and quotation rapidly follows another, sometimes without a sound reason even within paragraphs. Some sections, however, are well written.

The book is a worthwhile reference to have available, and I would hope that much of the information carried within its pages will reach practicing psychologists, psychiatrists and social workers as well as students.
—WALTER E. BOEK, PH.D., New York State Department of Health.

BATTLE FOR THE MIND

By William Sargant

New York, Doubleday & Company, 1957, 263 pp.

Dr. William Sargant, an English psychiatrist who has been identified with physical methods in psychiatry, attempts to explain varied psychological phenomena ranging from war neuroses to religious and political conversion by an application of Pavlov's theories based on findings in experiments with dogs. Those theories pertinent to this thesis were that dogs were of four temperamental types—strongly excitatory, lively, weak inhibitory, and calm imperturable or phlegmatic; and that a phenomenon called "transmarginal inhibition" took place when a dog had been stimulated beyond its capacity to react normally. This inhibition was considered a protective device and resulted in altered behavior in four distinguishable phases of increasing abnormality: in the "equivalent" phase, the same responses followed weak or strong stimuli; in the "paradoxical" phase the brain responded more actively to weak stimuli; and in the "ultra-paradoxical" phase conditioned responses and behavior patterns turned from positive to negative and negative to positive, a further degree of inhibitory activity which disrupted for the time being all recently implanted conditioned reflexes.

Using these experimental observations and theoretical concepts as a working hypothesis, Sargant investigated observations in a number of apparently unrelated areas of human behavior. He found evidence of the operation of these principles in war neuroses, drug therapy of mental illnesses, psychoanalysis, shock treatments, leucotomy, religious conversion, brain-washing and the eliciting of confessions. He supports this conclusion by extensive quotations from literature consisting of descriptions of these

physiological and psychological phenomena, by individuals who experienced them, by observers and by those who utilize these methods. He emphasizes the observation that it is the normal individual who is most susceptible to these methods.

In discussing methods of prevention he states that human beings, like dogs, do not break down if they refuse to accept the problem presented to them or take evasive action before their equilibrium is upset. He considers the degree of physiological cooperation or "transference" as the vital factor. A good sense of humor is a most effective defense.

He pleads for a greater understanding of the power and the comparative simplicity of the methods and for recognition that they are being used for evil purposes.

Dr. Sargant, by constricting his approach as he deems necessary for effective research, sees only the physiological effects of emotions generated by psychological means. The use of the adjective "physiological" to qualify the term "transference" indicates the difficulty he has in confining himself to "simple, physiological, mechanistic" methods.

The book is written in popular, narrative, entertaining style which carries the reader along in a convincing manner. There are two series of photographs portraying some of the "physiological" methods of conversion. The most impressive series is of a revival meeting of a poisonous snake-handling sect.

While it is difficult to accept Dr. Sargant's generalizations and conclusions, the book is thought-provoking. The material from the White Paper on the trial of a confessed murderer who was found innocent after execution suggests a re-evaluation of the validity of confessions obtained by current methods.—JOSEPH S. SKOBBA, M.D., Atlanta.

READING DIFFICULTIES: THEIR DIAGNOSIS AND CORRECTION

By Guy L. Bond
and Miles A. Tinker

New York, Appleton-Century-Crofts, 1957, 486 pp.

This book was written "because the authors firmly believe that the children who get into difficulty with reading need immediate help"—a most laudable goal. It is aimed at the classroom teacher, the school remedial teacher and the clinician. Its tightly packed pages seem to give very thorough coverage to almost every phase of remedial reading, including the nature and causes of reading difficulties, the diagnosis of difficulties, and remedial treatment. As is so often the case, such treatment also inevitably involves many brief but telling and helpful statement about good ways of teaching youngsters to read in the first place, so that difficulties are less apt to arise. The book seems sure to be widely used in college courses in remedial instruction. Its many references throughout to pertinent research, its comprehensiveness, and the specificity of its suggestions suit it well for this purpose.

There will be some who may quarrel with what seems to be the basic assumption of the authors, based on their observation: "The vast majority of reading cases are brought about through failure on the part of the child to acquire the necessary learnings" (p. 116) and with a counterpart observation that "in a relatively small proportion of the cases, children are emotionally upset and maladjusted when they arrive in school" (p. 110).

The authors, of course, consistently say that diagnosis must be thorough and that treatment depends on the outcome of the

diagnosis. But one senses a general belief that, in most instances, these children weren't taught right in the first place and that what they need now is more and better teaching. Although some slight stress is given to the need for good relationships, etc., and to the fact that retarded readers not uncommonly shy away from more reading, much more emphasis is given to specific techniques of teaching than to other ways in which adults can relate themselves to children.

It is to be hoped that despite its many good suggestions to the contrary, the book does not, through its tone rather than its words, fix remedial reading more rigidly in a pattern of more drill and more teaching for youngsters who so often have already had a bellyful."—JAMES L. HYMES, JR., University of Maryland.

PERSONALITY IN A COMMUNAL SOCIETY: AN ANALYSIS OF THE MENTAL HEALTH OF THE HUTTERITES

By Bert Kaplan and Thomas F. A. Plaut

Lawrence, Kans., University of Kansas Publications, 1956, 116 pp.

Personality in a Communal Society is a report of an interesting and important research effort, the purpose of which is "to evaluate the mental health of a cultural group." Employing a multidisciplinary approach, the investigators—a psychiatrist, a sociologist and two psychologists—attempted to penetrate the personal, social and cultural life of a selected study population of Hutterites, a sparsely scattered religious sect located in southern Canada and the centrally northernmost part of the United States.

The chief aims of the investigation were to ascertain the degrees of interrelatedness and the strengths of the nexuses between what many sociologists, anthropologists and social psychologists assume to be an inseparable trinity: personality (emotional and mental states), cultural patterns (living prescriptions and values) and societal processes (interpersonal and intergroup relations —consensus, understanding, *verstehen*).

The objectively dispassionate and scientific orientations and motivations of the authors are perhaps best demonstrated by their ready willingness to recognize, and to try to come to grips with, as far as possible, the apparent limitations, weaknesses and inevitable methodological foibles encountered by every research student who undertakes such an ambitious and courageous task as trying to uncover interdependent relationships between these three variables —the basic components of human conduct.

The frame of reference of mental health workers—"evaluative analyses for corrective purposes"—is one of the chief obstacles to scientific research. Evaluative research efforts usually harness students of human behavior with biases and assumption problems that, if recognized, produce complexities and dilemmas that are sometimes embarrassing. Moreover, the student frequently falls back upon his own personal empathy and value orientation which, in the final analysis, is impressionistic, based upon his own sensitivities and prejudgments.

For example, the authors had to settle upon certain operational definitions such as the "normal Hutterite" and the "average personality." They could come up with nothing more definitive than "more or less" —a definition much too loose for measurement and prediction. Still another prob-

lem was that of determining for research operations—the selection of cases—just what is precisely meant by "good mental health." In this instance, a person did not have good mental health if the staff psychiatrist so diagnosed his condition. Could it not be that some "cases" escaped the psychiatrist's detection; indeed, that some might have been misdiagnosed? Can a psychiatrist play a case-finding role successfully in a culture with which he is not familiar?

Projective techniques—the Murry thematic apperception test and the sentence completion test—were the chief instruments for studying "cases." The applicability of these research tools and of projective techniques in general is now recognized as a fruitful procedure for culture-personality studies. However, it was necessary because of uncontrollable field situations for the investigators to deviate from standard procedures in the administration of the test. How much did these improvised and indicated makeshift changes influence or alter test results?

One wonders why the authors expressed surprise in finding that several forms of mental disorders were present among the Hutterites, that although the Hutterites had many symptoms of psychoneuroses they nevertheless handled them well. This would be expected of any cultural group possessing the cohesiveness and solidarity of the Hutterites. The crucial and indeed relevant question in this connection is: How do the Hutterites themselves view these symptoms and the various forms of mental disorders found in the society? Do they feel and accept states of anxiety, fears and other emotional manifestations of behavior as common and everyday living phenomena or as situations that demand special attention?

Is it likely that one could find a society any place in time or space where individuals would be devoid of states of anxiety and would manifest no psychoneurotic symptoms? Are these individuals always considered as "cases"? Are all neuroses and even some psychoses bad? Again, what *is* good mental health?

Finally, the authors may have placed too much stake on the hypothesis that the personality of Hutterites is a correlative of their cultural patterns. But, despite these comments, this volume reports an excellent piece of research that is challenging, provocative and suggestive of further studies. The chief contribution of the authors is that they report a research experience with frankness, honesty and in the spirit of laboratory science; they place in bold relief important theoretical and methodological considerations for continuing multidisciplinary studies of cultural groups.—MOZELL C. HILL, Atlanta University.

AS YOU SEE IT

By Catherine E. Steltz

New York, Bureau of Publications, Teachers College, Columbia University, 1956.

As You See It is a series of 24 photographs of family life and community moral and social problems. The pictures are intended to be shown one at a time to individuals or groups to provoke discussion on such topics as alcoholism, divorce, sibling rivalry, premarital relations, discrimination and others. Accompanying the illustrations is a manual which serves as a guide for the leader using the series.

The manual includes a number of questions that may be used in introducing each of the photographs to the audience. Sample experiences in using the photographs in guidance situations and classrooms are

included. There is also a selected bibliography listing suitable publications related to the series.

This reviewer used some of these pictures with a group of teenage boys and girls and found that they were successful in stimulating discussion. However, it was later found that without these pictures at subsequent meetings the group talked equally as freely about similar problems that concerned them.

The value of this material, therefore, may be in its ability to focus on certain topics for discussion so that a wide range of social issues may be examined quickly.

The manual indicates that the pictures "are not difficult to use nor do they require any special training or skills beyond those required of any good discussion leader." This concept is questionable, since many of the photographs deal with instances of individual and social pathology. In handling such emotional-laden topics with groups it is necessary for the leader to have the skills mentioned and also to be well oriented in sociological and psychological understanding. This background is essential if the leader is to assist the group to understand what is happening to the people portrayed and to be able to help individuals express their feelings about some of the incidents which may be disturbing to them. Under skillful and professionally oriented leadership this visual aid may well serve as an additional device for a group leader to use in dealing with problems of human behavior.—EDWARD LINZER, National Association for Mental Health.

Notes and Comments

Mental Hygiene extends its appreciation and best wishes to the *Digest of Neurology and Psychiatry* published by the Institute of Living, Hartford, Conn. For the last 25 years it has provided briefs of choice contributions to the gradually developing structure of scientific psychiatry. Many of these contributions have originally appeared in American periodicals, and the briefs have made it easier to choose what should be read in full. They have also provided a glimpse into the important books of the day and into foreign scientific literature that would otherwise often escape attention.

The Institute of Living and its director, Dr. Francis J. Braceland, and his staff and especially the associate editor, Mary B. Jackson, deserve our thanks at the end of this quarter century of service.

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The National Association for Mental Health will lead the nation during Mental Health Week—April 27 to May 3—in the 10th annual citizens' mobilization aimed at focusing maximum public attention and action on the needs of the mentally ill.

Mental Health Week is endorsed by the federal government, co-sponsored by the National Institute of Mental Health, and coordinated by the 750 state and local mental health associations.

Many major organizations — business, labor, educational, civic, patriotic, fraternal, religious and governmental—participate by devoting at least one regular meeting to the observance of Mental Health Week.

The slogan this year is "With Your Help, the Mentally Ill Can Come Back." In line with this theme, all observances—national, state and local—will stress the hopeful aspects of the nation's fight against mental illness and urge the public to make it possible for more thousands of those now ill to be restored to their families and communities.

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The board of the National Association for Mental Health has recorded with sorrow the death on December 18 of Dr. Melvin M. Johnson, former sovereign grand commander of the Supreme Council, 33rd Degree, Ancient Accepted Scottish Rites of Freemasonry, Northern Masonic Jurisdiction. He was 86.

In a resolution passed at the January 18 meeting, the board noted that "it was his fertile mind that sensed the neglect of research in that most prevalent of mental disorders—schizophrenia. It was his compassionate heart that moved him to do something about it, to lead his Brothers to a like appreciation and to mobilize personal and financial resources to correct this neglect.

"He knew that the task would be a hard and slow one," the resolution went on, "but there was no alternative except retreat, and retreat was not in his makeup.

"The National Association for Mental Health is proud to have been associated with Commander Johnson and the Scottish Rite in this scientific advance, and is gratified with the impact that it has had on psychiatric research generally."

In the last 24 years the Scottish Rite has contributed more than $1,335,000 for research in the causes and treatment of schizophrenia. The program, conducted through

NAMH, is the only comprehensive, coordinated research aimed at schizophrenia.

* * *

San Francisco's doctors see mental health problems, especially alcoholism, as the community's top-priority health challenge, a recent survey shows.

Polled for their opinions on community health and rehabilitation needs and resources, the physicians said their waiting rooms were crowded with patients with mental health problems. A majority (62.1%) said they saw patients who needed psychiatric diagnosis and treatment other than that provided by the doctor, and about 35% saw patients needing institutional care, psychological testing and counseling.

Alcoholism and other mental illnesses and emotional disturbances are the conditions least adequately handled by the community, according to the doctors. Over 45% said services and facilities to combat alcoholism were the community's greatest unmet need. Over 35% said help for those suffering other mental illnesses or emotional disturbances was also greatly inadequate.

To deal with the mental illness problem, the doctors urged the community to provide coordinated follow-up services for discharged mental patients, including counseling, financial aid, vocational rehabilitation and job-finding.

They also recommended free and part-pay outpatient psychiatric services other than the outpatient clinic at San Francisco Hospital, more beds in general hospitals for psychiatric and alcoholic patients needing short-term intensive treatment, and an outpatient psychiatric clinic at the county hospital.

The poll of physicians was part of a 2-year health and rehabilitation survey conducted by the community mental health services committee of the United Community Fund of San Francisco.

TRAINING

Two new plans continuing the expansion of advanced graduate training for psychiatrists in New York state mental institutions were launched early in the year at Columbia University and the State University of New York, Upstate Medical Center in Syracuse. Dr. Paul H. Hoch, state commissioner of mental hygiene, said the courses will be operated by the Department of Mental Hygiene jointly with each of the universities.

The programs, an extension of the department's in-service training for psychiatric residents in state institutions, are aimed at providing experience in outpatient psychiatry as well as increased facilities for basic study.

RESEARCH

Research grants totaling $8,363,519 were awarded during the first 6 months of the 1957–58 fiscal year by the National Institute of Mental Health, the U. S. Public Health Service's research center at Bethesda, Md.

A total of 397 grants were made to scientists working on mental health research projects in universities, hospitals and other research centers throughout the nation.

They represent about 7% of the 5,459 grants—totaling $80,666,188—awarded by all the National Institutes of Health for research on cancer, heart disease, allergies and infectious diseases, arthritis and metabolic diseases, neurological diseases, blindness and other health problems.

* * *

A project to investigate vocational and socio-economic adjustment of patients newly

released from mental hospitals is underway in New York State with a $25,900 grant awarded by the U. S. Office of Vocational Rehabilitation. The study is being conducted by the Research Foundation for Mental Hygiene.

CARE AND TREATMENT

Only 13 states provide specialized treatment programs for mentally ill and emotionally disturbed children, according to a survey by the Illinois Department of Public Welfare.

About 1% of the residents of state mental hospitals are under 20, the study revealed.

Children are housed and treated along with adults in the mental hospitals of 37 states. Some hospitals have separate buildings or wards for boys and girls of certain ages, but 11 of the 37 states had no facilities of any kind for children except in the adult wards. Four states completely segregate children from adults, either in special wards or in separate hospital buildings.

LEGISLATION

New York's law on criminal insanity is undergoing searching study by a committee of 8 authorities on law and mental health. Their ultimate aim is to bring about revision of the law in line with modern thinking.

The present law, which derives from an 1843 decision of the British House of Lords, holds that a person is criminally liable for an act if he knows its nature and quality, and knows it is wrong. Many psychiatrists believe this too narrow a conception and favor a change in the direction of a 1954 decision by Judge David L. Bazelon of the U. S. Court of Appeals for the District of Columbia.

The decision by Judge Bazelon would require that a defendant be found "not criminally responsible if his unlawful act was the product of mental disease or mental defect."

* * *

Delaware has done away with court hearings for involuntary commitments to the state hospital for the mentally retarded. A new law now requires that a mental hygiene clinic or state psychiatrist file a certificate recommending hospitalization and signed by two Delaware physicians. The patient or anyone related to him by blood or marriage has the right to appeal the commitment to the Court of Chancery.

* * *

Indiana's mental health program took another forward step January 1 when new uniform commitment procedures and new laws affecting mental hospital admissions went into effect. They were recommended to the legislature by the Indiana Association for Mental Health.

If a mentally ill person does not have the necessary insight to recognize his need for care and treatment in a psychiatric hospital, Indiana courts may now authorize a temporary commitment for not more than 90 days on the petition of a member of the patient's family and of a licensed physician. Although this is a judicial action, the patient does not suffer the loss of his civil rights.

At the request of the hospital superintendent, the court may extend the commitment for another 90 days. If the patient is released within 180 days the temporary commitment is dismissed and expunged from the court records.

Regular commitment orders will be issued if the patient fails to improve sufficiently for release after 180 days of active treatment.

Indiana mental health authorities believe

most admissions to state mental hospitals will now be by voluntary application and by the new temporary commitment order.

* * *

Georgia's legislature has revised commitment procedures to express a modern, humane attitude toward the care and treatment of the mentally ill. Another new law creates a division of mental health in the State Department of Public Health, authorizes the establishment of state-wide facilities for the treatment of the mentally ill and allows for the training of professional and technical personnel.

Next November Georgians will vote on a constitutional amendment providing for scholarships to qualified students in psychiatry, clinical psychology, psychiatric nursing, psychiatric social work, occupational and recreational therapy.

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A marked increase in state and community mental health services over the country as a result of laws passed by state legislatures in 1957 was reported recently by Dr. Robert H. Felix, director of the National Institute of Mental Health.

Dr. Felix said the new laws would stimulate community mental health programs and improve conditions for the mentally ill.

California, Minnesota, New Jersey and Vermont passed laws providing grants-in-aid to localities for community mental health services such as mental health clinics, services for emotionally disturbed and mentally retarded children, rehabilitative and after-care programs, alcoholism control programs, and public education on mental health.

These laws resemble the first legislation of this kind which was passed in New York in 1954 and which provided that the state would pay half the cost of new or expanded community mental health programs. Connecticut, Pennsylvania, Indiana, Tennessee and Florida passed similar mental health legislation in 1955 and 1956.

Laws authorizing counties to levy taxes or appropriate funds to support local mental health centers or clinics were passed last year by Iowa, Kansas and South Dakota. California, Colorado, Kansas, Minnesota, Montana, North Dakota and Texas also took steps to modernize their laws on the commitment, detention and care, and treatment of the mentally ill.

Connecticut, Maine, Minnesota, New Hampshire, Oregon, Rhode Island and West Viriginia ratified the Interstate Compact on Mental Health. This agreement, issued in 1955, makes the patient's welfare the cardinal consideration in deciding whether he shall be kept in one state or sent to another. Other states participating in the compact are Massachusetts, New Jersey and New York.

Legislatures showed continued high interest in mental retardation. Arkansas, Nebraska and Texas authorized the construction of new institutions for the care and treatment of the mentally retarded. Idaho and Minnesota made it mandatory for local school districts to provide instruction for handicapped children. A diagnostic and training center for the mentally retarded will be established in the state of Washington, and New York is developing plans for a state research institute on mental retardation.

Several states took action to develop resident treatment for emotionally disturbed children. In Washington a resident treatment center for emotionally disturbed children is being established at Western State Hospital where research as well as treatment will be carried on. Minnesota authorized a resident treatment center for

emotionally disturbed children. In California the Youth Authority is initiating a special program of intensive treatment in two institutions for juvenile delinquents.

Some of the states took action to expand research and training activities. Texas is planning to set up a new community hospital near the Texas Medical Center in Houston for training and research in mental illness. Iowa instituted a Mental Health Research Fund. North Dakota directed the University of North Dakota Medical Center to encourage the training of psychiatric personnel for staffing mental health agencies and provided stipends for trainees.

HIGH COST OF MENTAL ILLNESS

Since World War II, California has spent $200,000,000 rebuilding most of its mental hospitals.

More than $100,000,000 of the state budget goes toward caring for the mentally ill.

These figures on the high cost of mental illness were included in a recent 4-part series of articles by Joseph J. Lipper of the Associated Press.

He said California's Short-Doyle act, which went into effect last fall, is proving a real shot-in-the-arm to the clinic movement. It mandates the state to pay half of the cost of local mental health services designed to prevent or combat mental illness.

San Francisco, Contra Costa County, Los Angeles (city and county), Long Beach and San Luis Obispo took steps at once to expand facilities they already had. San Diego, Santa Barbara, Marin, Placer, San Bernardino, Kern, Alameda and San Joaquin counties are establishing local mental health services for the first time, as is the city of San Jose.

The new community mental health services act will provide for 5 basic types of help:

- Out-patient services in psychiatric clinics.
- Up to 90 days of in-patient psychiatric services in general hospitals.
- Rehabilitation services for psychiatric patients in clinics, general hospitals or special centers.
- Informational and educational services to the public and to the professions and agencies concerned with mental health.
- Mental health consultation services for the staffs of schools and health, welfare and probation departments to help them deal more effectively with their students' or clients' mental health problems before they become so severe as to require psychiatric treatment.

When the Short-Doyle act went into effect there were about 54 community clinics in California. The mental hygiene department figures that within a year the number and capacity will double.

The new legislation also promotes the idea that general hospitals should admit mental patients, a measure vigorously endorsed by the California Medical Association.

WORLD MENTAL HEALTH

The World Federation for Mental Health has designated 1960 as the first World Mental Health Year.

The 18-month observance, to start January 1, 1960, will culminate in the 5th International Congress on Mental Health in Paris in August 1961.

Preparations for the World Mental Health Year are already under way under the aegis

of an international committee composed of Dr. Frank Fremont-Smith of the U. S., chairman, and Dr. John R. Rees of England, Dr. Brock Chisholm of Canada and Dr. Paul Sivadon of France.

The 32 U. S. organizations which are members of the World Federation for Mental Health will set up a steering committee to guide the U. S. share in the world-wide undertaking.

In addition to their common objectives for the year, different countries will pursue special projects of their own choosing, in the main designed to reveal the status and needs of mental health and to develop new resources.

APPOINTMENTS

Richard P. Swigart, executive director, has announced the appointment of Morris Klapper as assistant executive director in charge of program for the National Association for Mental Health. Mr. Klapper will also be responsible for certain phases of field operations.

He is a graduate of the University of Oregon and has a master's degree from the New York School of Social Work with a major in psychiatric social work. For the last 13 years he has been involved in various phases of social work administration, community organization and program.

For several years he was assistant director of the Altro Health and Rehabilitation Services in New York City; resident executive director of Blythedale, residential orthopedic rehabilitation center for children, and most recently executive director of United Cerebral Palsy of New York City. He has worked closely with New York City's departments of welfare, health, education, hospitals and mental hygiene, and is the author or co-author of several articles on rehabilitation.

Mr. Klapper began his duties with NAMH on March 1.

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Dr. Daniel Blain's resignation as medical director of the American Psychiatric Association, effective next September 1, has been announced by Dr. Harry C. Solomon, APA president.

Dr. Blain will continue to direct special projects for APA. He has been medical director since 1948.

In resigning, Dr. Blain said he wished to devote his entire attention to selected problems that are major stumbling blocks to further progress in conquering mental illness. He cited the shortage of psychiatrists to staff mental hospitals and other community services as the greatest single impediment.

No successor to Dr. Blain has been named. A committee of the APA council is searching for a qualified person.

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A 6-member panel of non-government experts is providing consultation to the National Institute of Mental Health on the mental health research program conducted in federal laboratories and other facilities at Bethesda, Md. and at field stations.

The membership of the new panel, known as the NIMH board of scientific counselors, is apportioned selectively between clinical and fundamental science categories to maintain balanced perspective. Individually the board members are outstanding in the professional and scientific specialties that are represented in the Institute's research activities.

In addition to reviewing the Institute's scientific activities, the counselors will provide the NIMH director with objective viewpoints and guidelines on the long-range perspective of intramural research.

The members are Dr. Horace W. Magoun, professor of anatomy at the University of California School of Medicine; Dr. John Benjamin, Child Research Council, University of Colorado School of Medicine; Dr. Stanley Cobb, Bullard professor emeritus of neuropathology at the Harvard University School of Medicine; Dr. Jordi Folch-Pi, director of scientific research at McLean Hospital, Waverly, Mass.; Dr. Robert F. Bales, associate professor of social relations at Harvard, and Dr. Neal E. Miller, Angell professor of psychology at the Yale Institute of Human Relations.

MEETINGS

Content and methods in mental education will be the subject of a national conference to be co-sponsored by the National Association for Mental Health, Pennsylvania Mental Health, Inc. and the American Psychiatric Association. It will be held next fall.

The assembly is conceived as a necessary first step toward meeting the need for a comprehensive and realistic appraisal of the educational aspects of the mental health movement. It will bring together for intensive deliberations the best minds in the various areas impinging on this field.

Serving on the steering committee are Dr. John Perry Horlacher, chairman of the program evaluation project of PMH; Donald A. Crawford, PMH treasurer; Robert L. Robinson, APA public information director; Michael Amrine, public information director of the American Psychological Association, and Edward Linzer, NAMH education director.

The committee is now nominating possible participants in the conference from the fields of education, psychiatry, psychology, social work, sociology, public opinion research, theology, public health, anthropology and mass communications.

The importance of mental health in all programs for young people was underscored in recent preliminary discussions on a theme for the 1960 White House Conference on Children and Youth. The discussions were sponsored by the U. S. Children's Bureau.

White House Conferences on Children and Youth are held every 10 years at the call of the President. The 1950 conference, attended by more than 5,000, had as its theme, "A Healthy Personality for Every Child."

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Five national organizations will sponsor a working conference on volunteer services for psychiatric patients June 12–17 in Chicago. They are the National Association for Mental Health, American Psychiatric Association, Veterans Administration, American Hospital Association and American Red Cross.

The conference will focus on the current status and purposes of volunteer programs, recruitment, training and screening of volunteers, administration of volunteer programs and new opportunities for volunteers, particularly in the rehabilitation of mental patients. Committees are preparing detailed working papers as a basis for discussions of these topics. Following the meeting, the APA will publish a comprehensive report.

A steering committee composed of two representatives from each sponsoring organization is planning the conference. They are Mrs. Marjorie H. Frank and Miss Mary Mackin, representing NAMH; Dr. Daniel Blain and Dr. Harvey J. Tompkins, APA; Dr. Leon L. Rackow and James H. Parke, VA; Mrs. Viola Pinanski and Mrs. George C. Capan, AHA, and Mrs. Abbott Mills and Miss Phoebe Steffey, ARC.

They have drawn up the invitation list,

limited to 65 professional and volunteer workers outstandingly equipped by knowledge and experience to contribute to the discussions.

The National Institute of Mental Health is subsidizing the project.

* * *

The Family Service Association of America, pioneer national social agency, will sponsor a 3-day scientific and professional symposium on family life in April 1959 in Washington, D. C. Experts in the social sciences, mental health, demography, public assistance, education, industry, government, religion and social welfare will take part.

The meeting will cover such topics as whether the modern family is too self-centered in its interests, trends in separation and divorce, to what extent families are gaining from new knowledge about health, whether social security and public assistance are adequate for poor families and whether the state of the national economy is harming everyday family life.

PUBLICATIONS

The National Association for Mental Health has published a new pamphlet called *Clergyman's Guide to Recognizing Serious Mental Illness.* It was written by the Rev. Thomas W. Klink, supervising chaplain of Topeka State Hospital and is the fourth in a series for clergymen of all faiths.

The interest of churchmen in the battle against mental illness has grown since the first of the series was published some years ago. It was *The Clergy and Mental Health.* Others were *Ministering to Families of the Mentally Ill* and *Pastoral Help in Serious Mental Illness.*

All three deal with the clergy's responsibility toward the mentally ill. The fourth explains 10 different signs of serious mental illness and illustrates each symptom with examples. The pamphlet stresses that diagnosis is not the clergyman's responsibility, but the doctor's. The clergy, however, must know how to help the mentally ill person find care and treatment.

The series of pamphlets has had wide acclaim by clergymen of various faiths. Of *Pastoral Help in Serious Mental Illness,* third in the series, the Rev. Henry H. Wiesbauer, Protestant chaplain at the State Hospital of Westborough, Mass., reports: "The Unitarian Association of this New England area found it the most practical material they'd come across, from the point of view of the parish clergymen."

The Rev. William C. Bier, associate professor of psychology at Fordham University, says: "The Catholic priest, not less than other clergymen, will be helped by suggestions contained in this simply-written, non-technical pamphlet, because serious mental illness is a common problem which knows no distinction of creed or color."

Copies of the fourth pamphlet, like the others, are available from NAMH, 10 Columbus Circle, New York 19, for 10¢ each.

* * *

The National Health Council has published the proceedings of its 1957 forum in a 128-page booklet called *Steps for Today towards Better Mental Health.* It contains major addresses by Dr. Francis J. Braceland, Harold D. Lasswell, Dr. Margaret Mead, Gov. G. Mennen Williams, Dr. David B. Allman, Dr. Jack R. Ewalt and Dr. Winfred Overholser, among others. It also digests 15 discussions on helping people to meet crises, promoting mental health, and community action for mental health.

The book ranges in scope from an analysis of the impact of mental illness and the mental health movement on civilization to such specifics as in-service training programs and community studies. From it the reader gains a broad view of the movement, an understanding of its various aspects and many "pointers to action."

Copies are available from the National Health Council, 1790 Broadway, New York 19, for $1.50 each.

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What is mental illness? How is it treated? Where? By whom? What are the chances of recovery?

These and other questions are answered in a new 32-page booklet, *Basic Facts About Mental Illness,* by Harry Milt, public information director of the National Association for Mental Health.

Dr. George S. Stevenson, NAMH medical consultant, notes in a foreword that "this booklet brings together in a single publication a comprehensive fund of basic information about mental illness, and in such a manner as to maintain readability and scitific soundness."

The booklet describes the symptoms of many of the more common types of mental illness. The intent of the pamphlet is not to make lay psychiatrists or amateur diagnosticians of its readers but to enable them to recognize symptoms which may suggest referral of the individual to qualified medical sources for help. Among the treatment methods reviewed are individual psychotherapy, group therapy, psychoanalysis, drug therapy, shock therapy and psychosurgery.

The booklet contains much information of value to all professional workers and laymen in fields related to mental health; to volunteers in mental health associations; to editors, reporters and writers; and to trade union counselors, police and probation officers.

Basic Facts About Mental Illness is available for 50¢ a copy from NAMH.

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More than 63,000 new employees are needed to bring public mental hospitals up to the minimum standards for adequate care and treatment of the mentally ill.

This is the situation reported in *Fact Sheet No. 4,* published last December by the Joint Information Service co-sponsored by the National Association for Mental Health and the American Psychiatric Association.

The hospitals lack 80% of the nurses needed, almost 64% of the social workers, 55% of the doctors, 35% of the psychologists and 24% of the attendants.

The report does not lay all the blame on lack of funds. It notes that shortages in a particular category may be caused by a nation-wide shortage, by a local shortage or by employment practices that deter jobhunters.

The report is based on an exhaustive study made by the Joint Information Service and reported in a monograph titled *Thirteen Indices: An Aid in Reviewing State Mental Health and Hospital Programs.* The monograph contains 13 tables and 48 charts showing how the states stand in relation to one another as to patients per 1,000 population, adequacy of staffs, daily maintenance expenditures per patient, number of psychiatrists per 100,000 population, professional man-hours in outpatient clinics, yearly per capita expenditures for mental hospitals, maintenance expenditure as percentage of total state expenditure and personal income, per capita total state general expenditure, per capita total state general revenue and per capita personal income.

Twelve of the 13 tables are based on 1956 data. There are individual charts for each state.

Copies of *Thirteen Indices* are available from NAMH for $1 each.

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Typical personality types found in every office and factory are described in a new 112-page illustrated handbook for supervisors, *Human Understanding in Industry*. It was written by Dr. William C. Menninger and Dr. Harry Levinson, both of the Menninger Foundation, to help supervisors understand how the human personality functions.

A separate leader's guide makes practical suggestions for a series of meetings.

Both handbook and guide are available from NAMH, 10 Columbus Circle, New York 19. The handbook is $2.25, the guide 50¢.

Another new pamphlet to help supervisors understand their employees' emotional upsets is *Emotional First Aid on the Job*. It was written by Dr. Levinson and is reprinted from the *Menninger Quarterly*. Copies are available for 10¢ each from NAMH.

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The National Association for Mental Health has published a revision of one of the classics in the field of mental health education. It is *Do Cows Have Neuroses?*

The booklet, long a favorite with the general public, tells how normal, neurotic and psychotic behavior differ. The concluding section suggests ways for a troubled person to find help. The booklet's readable text and amusing illustrations make it widely useful to schools and organizations of all kinds.

Copies are available for 25¢ each from NAMH, with special prices for quantity lots.

NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Voluntary Promotional Agency of the Mental Hygiene Movement founded by Clifford W. Beers

OBJECTIVES: The National Association for Mental Health is a coordinated citizens organization working toward the improved care and treatment of the mentally ill and handicapped; for improved methods and services in research, prevention, detection, diagnosis and treatment of mental illnesses and handicaps; and for the promotion of mental health.
